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Report of Inquiry into Motor Vehicle Accident Compensation in Ontario

The Honourable Mr. Justice
Coulter A. Osborne
Supreme Court of Ontario
Commissioner

Volume I

Ontario

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Report of Inquiry into Motor Vehicle Accident Compensation in Ontario

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FROM FLORIDA
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Ontario

The Honourable
Mr. Justice
Coulter A. Osborne
Commissioner

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Inquiry Into Motor Vehicle Accident
Compensation in Ontario

Enquête sur l'indemnisation des
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en Ontario

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February 11, 1988

The Honourable Ian G. Scott
Ministry of the Attorney General
18 King Street East
18th Floor
Toronto, Ontario
M5C 1C5

Dear Mr. Attorney:

With this letter I transmit my Report of the Inquiry Into Motor Vehicle Accident Compensation in Ontario.

Yours very truly,



Coulter A. Osborne
Commissioner

Encl.

Ontario

The Honourable
Mr. Justice
Coulter A. Osborne
Commissioner

John I. Laskin
Counsel

Steven Sharpe
Associate Counsel

Thomas B. Millar
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Inquiry Into Motor Vehicle Accident
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February 11, 1988

The Honourable Robert F. Nixon
Ministry of Financial Institutions
7th Floor, Frost Building South
7 Queen's Park Crescent East
Toronto, Ontario
M7A 1Y7

Dear Mr. Minister:

With this letter I transmit my Report of the Inquiry Into Motor Vehicle Accident Compensation in Ontario.

Yours very truly,

Coulter A. Osborne
Commissioner

Encl.

Ontario
Executive Council

Order in Council

On the recommendation of the undersigned, the Lieutenant Governor, by and with the advice and concurrence of the Executive Council, orders that

WHEREAS the Report of the Ontario Task Force on Insurance tabled in the Legislature on May 6, 1986 recommended that the Ontario Government work with the insurance industry to devise a framework for the private delivery of a new system of personal injury compensation and the elimination of resort to the law of tort and the litigation process with respect to personal injury compensation from automobile accidents;

AND WHEREAS the Ontario Law Reform Commission submitted a Report on Motor Vehicle Accident Compensation in 1973 recommending that provisions be made for compensating, without regard to fault, all pecuniary losses due to personal injury, property damage or death caused by a motor vehicle, by means of a compulsory motor vehicle accident insurance policy to be carried by the owner of every motor vehicle and that first party insurance should be adopted as the method of underwriting no-fault motor vehicle accident compensation;

AND WHEREAS the Select Committee of the Legislature on Company Law recommended the creation of a no-fault insurance scheme for compensation for injury suffered as a result of a motor vehicle accident;

AND WHEREAS concerns have been raised about the availability and affordability of automobile insurance in Ontario;

AND WHEREAS the Ontario Task Force on Insurance received many thoughtful and constructive suggestions for tort reform which would enhance the predictability of risk and the ability of the insurance industry to serve the public and concluded that some of the suggestions have immediate merit but others require more careful study;

AND WHEREAS the Ontario Task Force on Insurance concluded that serious research and planning should be undertaken in Ontario in anticipation of fundamental reforms to the current accident compensation and deterrent systems;

AND WHEREAS it now appears desirable to evaluate the merits of the existing tort system of compensation for injury by automobile accident, various recommendations for improvement of the tort system and the question of whether a no-fault automobile accident compensation system would better serve the people of Ontario;

NOW THEREFORE on the recommendation of the Attorney General and the Minister of Financial Institutions, the Lieutenant Governor by and with the advice and concurrence of the Executive Council, orders that the Honourable Coulter Arthur Anthony Osborne, a Judge of the Supreme Court of Ontario, member of the High Court of Justice and ex officio a member of the Court of Appeal, be authorized to inquire into and report to the Attorney General and Minister of Financial Institutions by November 1st, 1987 on the tort system of compensation for injury by automobile accident and the consequences of the implementation of a no-fault automobile accident insurance scheme and, in particular, to consider and report on:

The adequacy, timeliness and fairness of compensation to accident victims under the present tort system;

The effectiveness of the tort system as a deterrent and compensation mechanism;

The implications of removing tort liability as a basis for compensation in automobile accidents and replacing it with a no-fault system;

The cost savings and effectiveness of a no-fault system for compensation for claims arising out of automobile accidents;

The appropriate design of a no-fault automobile insurance system for Ontario, including the effectiveness of deterrence in a no-fault system, the effectiveness of driver performance related rating systems and standards for rating under such a no-fault automobile insurance system;

The desirability of a modified no-fault system with some form of threshold at which recourse to the tort system would be allowed;

The basis for determining compensation for injury or death in a no-fault system;

Dispute resolution and appeal processes for claims in a no-fault system;

The need in a no-fault system for a catastrophic claims fund or pooling mechanism to protect small insurers;

Private versus public delivery of a no-fault system of automobile insurance; and,

The role of government in any proposed no-fault system;

AND THAT an Advisory Committee shall be established by His Lordship to be comprised of members appointed in consultation with the Attorney General and Minister of Financial Institutions;

AND THAT His Lordship may, if he deems it advisable, request the Lieutenant Governor, by and with the advice and concurrence of the Executive Council, to provide him with any additional powers or resources necessary in order to carry out his duties and functions;

AND THAT all Government Ministries, Boards, Agencies and Commissions shall assist His Lordship to the fullest extent in order that he may carry out his duties and functions, and that he shall have authority to engage such counsel, expert technical advisors, investigators and other staff as he deems it proper, at rates of remuneration and reimbursement to be approved by the Management Board of Cabinet;

AND THAT the Ministry of the Attorney General and the Ministry of Financial Institutions shall be responsible for providing administrative support to the inquiry.

Recommended _____
Attorney General

Concurred _____
Chairman

Recommended _____
Minister of Financial Institutions

Approved and Ordered November 6, 1986
Date

_____
Lieutenant Governor

F O R E W O R D

Through this short note, I express my appreciation to a loyal and most helpful staff.

To Inquiry administrator Thomas Millar I offer my thanks for efficiently relieving me of virtually all the unwanted burdens of administration. I am also grateful to our librarian Ishmael Doku, Kersi Chesson and the ever helpful Harry Rickard for consistently making life easier for me during this Inquiry.

I want to especially recognize the contributions of Inquiry secretaries Helen Warburton, Eveline Bill, and in the latter stages, Gail Estabrooks and Elizabeth Sinclair. I also wish to thank Marian Makar, Lucy Villamagna, Linda Haines and MaryAnne Kneif for their dedicated assistance throughout the production of this Report.

Our actuary, Joe Cheng, who cerebrates at a different level from us all, made it possible for me to begin to understand the principles of insurance and the anatomy of automobile insurance claims. I thank him for his patience, help and understanding.

I particularly want to mention the work of Nancy Reason and Saskia Matheson. Both were of invaluable assistance. My thanks as well to Steven Sharpe for his help through the hearings stages of this Inquiry.

Then there is John I. Laskin. In this short space, I cannot adequately express my appreciation for John Laskin's work from the very beginning of this undertaking to the completion of this Report. A keenly analytical mind, wise counsel, a sound sense of basic fairness and plain hard work are among John Laskin's many contributions to this undertaking.

To all the inhabitants of the 22nd Floor, 180 Dundas Street West, who were involved in this work, I offer my thanks.

COMMISSIONER
The Honourable Mr. Justice Coulter A. A. Osborne

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CHAPTER 1

SUMMARY OF FINDINGS AND RECOMMENDATIONS

Although there are eleven issues specifically referred to in the Order-in-Council establishing this Inquiry, two issues, no fault automobile insurance and public automobile insurance, dominate.

The notion of no fault automobile insurance is not new. It was recommended in 1932 in what has come to be known as the Columbia Report. A form of no fault automobile insurance was proposed by Professors Keeton and O'Connell in 1965. In Ontario, no fault automobile insurance was recommended by the Ontario Law Reform Commission in 1973, in a modified form by the Select Committee on Company Law in 1978 and by the Ontario Task Force on Insurance in 1986. We have had no fault compensation for workplace injuries in Ontario since 1914. No fault benefits have been a part of the Ontario automobile insurance policy since 1972.

Threshold no fault automobile insurance is an American no fault/tort system compromise. Threshold no fault was first introduced in the United States in the 1970s. In threshold no fault, expanded no fault benefits are funded by denying the less seriously injured compensation for pain and suffering.

In considering the appropriate system of compensation for those injured in motor vehicle accidents in Ontario, I have looked to the experience of other jurisdictions such as Quebec, Australia, New Zealand, Great Britain, Switzerland, France, West Germany and a number of American states. It quickly became apparent to me that motor vehicle accident compensation should not be considered in a vacuum. Social conditions, the availability of long-and

short-term disability coverage and existing social programmes must all be taken into account.

We live in a province which provides universal medical and hospital care. Billing beyond the schedule of fees prescribed by O.H.I.P. has been prohibited. No fault benefits are a compulsory part of the standard form of automobile insurance policy. Automobile insurance third party limits are $200,000. The average insured motorist has third party coverage of more than $500,000. Automobile insurance is compulsory. Less than 2% of Ontario drivers are uninsured. All Ontario drivers have uninsured/unidentified coverage. Over 90% of Ontario drivers have underinsured coverage. Non-economic compensation is capped at $100,000 (1978 dollars). Jury verdicts are subject to reasonable review by our appellate courts. Few motor vehicle accidents clog our courts at the trial level.

Steadily increasing bodily injury claims costs have led some to conclude that Ontario is now, or is soon to become, the "California of the North". This conclusion seems to me to be more rhetorical than substantive. It is consistently supported by anecdotal evidence, data confirming the steady increase in bodily injury loss costs and a specific reference to one case, McErlean v. City of Brampton. I have chosen to ignore the anecdotal evidence and I have attempted to determine if and why bodily injury loss costs have increased. The relevance of the above-mentioned McErlean case, the flagship of the "California of the North" fleet, has been dramatically reduced because of the Court of Appeal's reversal of the trial judgment on both liability and damages. The judgment of the Court of Appeal seems to me to have reduced the anxiety levels of some segments of the insurance and reinsurance industries. I note that the November 1987 issue of the Canadian

Underwriter contained this comment in a concluding reference to the Court of Appeal's judgment--"Goodbye California of the North".

Threshold no fault has been recommended by many, including the Insurance Bureau of Canada. The model most frequently looked to is Michigan's threshold no fault plan. I thought it necessary to review and assess the Michigan threshold no fault compensation scheme in some depth. I have travelled to Michigan, discussed the Michigan plan with state legislators, the Michigan Commissioner of Insurance and his staff. I have sought the views of Michigan judges and lawyers on compensation and insurance issues. In the end result, I think I understand why Michigan introduced threshold no fault automobile insurance and how the Michigan plan has operated in practice.

Social conditions and insurance circumstances prevailing in Ontario are far different from those which dominated the Michigan motor vehicle accident compensation debate in the 1970s. For reasons which will be developed in the main body of this Report, I have concluded that aside from the provision of a modest degree of additional stability for automobile insurers, cost/premium decreases would be modest were we to proceed to threshold no fault and those modest cost savings would be imported on the backs of over 90% of injured Ontario motorists who now have the right to seek non-economic compensation.

I should make it clear at the outset that were the tort system alone to be a compensation option, I would reject it out of hand. There is, however, room for peaceful co-existence between tort and no fault. Humane rehabilitation and long-term care can be provided on a no fault basis. Death benefits, reasonable income

replacement benefits, homemakers' benefits and provision for child care, can also be provided on a no fault basis. This can be done at a reasonable cost and without eroding the values inherent in tort law which I view to extend beyond the perimeters of compensation and deterrence.

I do not accept the argument that either pure no fault or threshold no fault automobile insurance is justified as a first step to comprehensive accident or disability compensation. While I am of the view that comprehensive compensation ought to be given further consideration, in practical terms, we are not remotely close to implementing a system of comprehensive compensation for accident victims or for the disabled. The second step is too far removed from the first step. Thus, the first step must be looked at on its own. There are existing problems which require immediate, common sense solutions. It seems to me realistic, quite apart from the provisions of the Order-in-Council establishing this Inquiry, that I consider no fault automobile insurance on its own merits.

In the end result, I hope after considering all positions fairly, I have reached the conclusion that existing no fault benefits ought to be substantially expanded, made truly no fault in their character and that the right to individual compensation in the tort system ought to be maintained. In the system I have proposed, the need to sue has been reduced; the right to sue has been preserved. Having looked at a great number of compensation systems, in the final analysis, it seems to me that while our system is far from perfect, Ontario should be an exporter, not an importer of compensation systems.

There is, as well, the public automobile insurance issue. Quebec, Manitoba, Saskatchewan and British Columbia all deliver automobile insurance through public monopolies. Saskatchewan's plan has been in place since 1946. While it can be said that there is a lengthy history of a free market economy in Ontario, public delivery of automobile insurance in Canada has been established for a considerable time in four of ten Canadian provinces. I have looked to the experience of those provinces having public plans for guidance.

I have attempted to deal with the public automobile insurance issue by asking and then answering this central question, "Will Ontario's motorists be the beneficiaries of efficiency gains and thus lower premiums were Ontario to deliver automobile insurance through a public monopoly?"

In the absence of clear and convincing evidence of efficiency gains, it seems to me that there is no more justification for nationalizing the automobile insurance industry than there is for nationalizing any other industry.

While the private sector automobile insurance industry has in many respects been its own worst enemy, sensible rate regulation and reasonable external control of claims and underwriting practices should eliminate many problems about which consumers have legitimately complained. There is no reliable evidence that consumers will benefit were Ontario to nationalize the automobile insurance industry and deliver automobile insurance through a public monopoly.

The following is a summary of the major findings and the recommendations contained in this Report. Both the findings and recommendations are listed by subject. The findings are prefaced by the letter "F" and the recommendations by the letter "R". The number in brackets after each finding and recommendation indicates the page(s) in the Report where the finding or recommendation is located.

A. THE AUTOMOBILE INSURANCE INDUSTRY IN ONTARIO (Chapter 4)

Structure

F1. The automobile insurance market in Ontario is unconcentrated. Based on premium income the top ten insurers in Ontario have 53% of the market; the top twenty insurers have 74% of the market. (95)

F2. Approximately 98% of motor vehicle owners in Ontario are insured. (97)

F3. As of August 1987, 1.7% of private passenger vehicles in Ontario were insured through the Facility Association. Facility Association private passenger basic premiums are about 205% of the weighted average standard market premiums. As of its 1986 year-end, the Facility Association showed a deficiency of expenses over revenue of $29.6 million; Ontario's losses equal 52% of the total Canadian losses, or more than all the other provinces combined. (101-102)

F4. 28.79% of Facility Association drivers are five-year claims-free drivers; 80.79% of those insured through the regular market are five-year claims-free drivers. (105)

F5. The loss experience for Toronto fleet taxis is so bad that even with the substantial Facility Association premiums, taxi risks are almost uninsurable. In 1985 3.6% of Toronto territory taxis were insured through the Facility Association; in 1986, 50.3% of Toronto territory taxis were insured through the Facility Association. The regular market has stopped writing taxi business except for owner-operated taxis and in some circumstances co-operative taxis. (107-108)

F6. Ontario drivers insured in the regular market are subsidizing through their premiums those insured in the Facility Association. (109)

Marketing

F7. About 74% of automobile insurance sold in Ontario measured by premiums is provided through independent brokers; virtually all of the remaining 26% is marketed through direct sales agents. (109)

F8. A broker may represent any number of insurers and as few as one insurer (aside from a Facility Association servicing carrier). (111-112)

F9. Brokers are and will likely continue to be an

integral part of the automobile insurance delivery system in Ontario. (113)

F10. Independent brokers are not independent once under contract to an insurer. At that point brokers are largely dependent for economic survival on the insurers they represent. (114)

F11. Insurers provide a great variety of incentives and rewards to their brokers, the cost of which increases business acquisition expense and eventually premiums. (114)

F12. The established insurers/broker structure reeks of conflict. The broker often chooses one insurer over another in consideration of a number of factors unknown to the applicant for automobile insurance. (114)

F13. The quantum of the broker's commission is almost never disclosed to the consumer; the consumer knows neither the commission rate nor the variation in commission rates among insurers the broker represents. (114)

F14. The broker has no obligation to disclose and often does not disclose any competitive premiums even among those insurers represented by the broker. As a result, in many instances, the consumer has limited information about premiums of the broker's other insurers and no access to information about companies not represented by the broker. (115)

F15. The broker's right to represent an insurer can generally be terminated on relatively short notice. Termination can have a detrimental effect on both the insured and the broker. (115)

F16. An insurer's termination of its contractual arrangements with brokers typically arises as a result of poor loss ratio, unacceptable mix of business, the failure to satisfy the insurer's accompanying business requirements, unacceptable balance of business and inadequate volume of business. (116)

F17. Insurers should be prohibited from using the number of occasions within a given period that an applicant for insurance has changed insurers as an underwriting criterion. (128-129)

R1. Brokers should not be required to belong to any specific association or organization. (110)

R2. The education programmes sponsored by the I.B.A.O. and the T.I.C. are useful and should be encouraged. (110)

R3. A control mechanism should be established, so that insurers represented by a given broker can be identified and so that brokers who represent no automobile insurer other than a Facility Association servicing carrier can also be identified. (111)

R4. At regular intervals throughout the year, the Office of the Superintendent of Insurance should

publish basic rates of automobile insurance to ensure province-wide exposure. The consumer should also be informed of typical surcharges. (119)

R5. *Brokers and agents should be required to display prominently the names of insurers for whom they act. (120)*

R6. *Each broker should clearly identify the broker's Facility Association servicing carrier.*

R7. *All brokers should be required by legislation to provide access to the residual market (the Facility Association) through a designated servicing carrier.*

R8. *In cases other than fraud, dishonesty, etc. insurers should be required to give some minimum notice of termination to brokers. The minimum notice period should be examined through consultation between insurers and brokers. (120-121)*

R9. *Insurers terminating contracts with brokers should be required to give specific reasons for the termination. An arbitration structure through the I.B.C. and the I.B.A.O. to deal with broker/insurer disputes, including terminations, should be established. (121)*

R10. *An insurer terminating its contract with a broker because of mix, balance or volume of business, or loss ratio, should be encouraged to enter into a rehabilitation programme with the terminated*

broker. Automobile insurance companies and brokers, together with the Superintendent of Insurance and R.I.B.O., should enter into discussions to establish guidelines for the use of rehabilitation programmes particularly when loss ratio is the basis of an insurer's decision to terminate its contract with a broker. (121-122)

R11. Upon a broker cancellation by an insurer, the cancelled broker should be obligated to inform the insured that he is no longer acting for that particular insurer and that if the consumer wishes to continue with that insurer, the consumer should contact the insurer to obtain information about other brokers writing its business. (123)

R12. The guidelines for broker termination established by the I.B.C. and the Canadian Federation of Insurance Agents and Brokers Association should be implemented. The Superintendent of Insurance should carefully monitor broker terminations to ensure these guidelines are being followed and to ensure that insureds will not be unfairly affected by having to pay increased premiums as a direct result of the insurer's termination of a broker. An insured should not be adversely affected by issues having relevance only to a broker and an insurer. (123-125)

R13. A breakdown of an insured's automobile insurance premium payment, including the broker's commission, should be provided in all cases. (125)

R14. The broker's Facility Association commission is no different than any other commission and should be disclosed to the consumer. (127)

R15. Brokers should be encouraged to give premium quotations by telephone. These quotations should be non-binding. (127)

R16. The Registered Insurance Brokers Act should be amended to prohibit any broker from acting only for a Facility Association servicing carrier. (128)

R17. Banks and trust companies should be entitled to market automobile insurance. (128)

R18. The prohibition on part-time brokerage activity should be re-examined. (128-129)

R19. Insureds having a claim against a negligent broker should not be denied compensation from the broker's liability insurer because of policy violations by the broker. (129)

B. COVERAGE AND DELIVERY PROBLEMS (Chapter 5)

Coverage and Delivery

F18. There are relatively few consumer complaints related to the resolution of bodily injury and property damage claims. (140)

F19. Insureds have no real access to any dispute mechanism through which to challenge the

allocation of fault as determined by the fault chart. (141)

F20. Third party liability limits should not be open-ended because of solvency considerations; even the benefits attendant upon increased policy limits do not out-weigh the costs. (142)

F21. Delay is a problem in the payment of third party bodily injury claims. The root cause of delay aside from congested court lists in some areas is the lump sum payment compensation system which requires bodily injuries and disabilities to be stabilized before settlement or trial can realistically be considered. The bodily injury delay problem does not have anything to do with the automobile policy or with automobile insurers. (143)

F22. Delay is not a problem in the resolution of property damage claims. (143)

F23. The concept of the O.H.I.P. Bulk Subrogation Agreement is sound. The O.H.I.P. agreement has resulted in significant cost savings. (146)

F24. O.H.I.P. is sustaining losses by reason of the fact that some insureds have established special arrangements through fronting policies with their automobile insurer. (147-148)

F25. Because of the looseness of the definition of rehabilitation and its interpretation by insurers many injured persons in need of rehabilitation and

contractually entitled to it are not receiving it. (161)

F26. The contractual obligation on the part of insurers to pay first party rehabilitation benefits only upon the rehabilitation expense having been incurred is destabilizing and results in delayed or no rehabilitation in many cases. The system has not properly responded to the rehabilitation needs of those injured in motor vehicle accidents who reasonably require out-of-hospital rehabilitation. (162)

F27. The insurer through its medical advisor should not have prima facie veto rights over proposed rehabilitation; the insured's medical advisor's opinion as to rehabilitation and the opinion of rehabilitation counsellors should be of primary evidentiary significance. (162-163)

F28. Very few insurers recognize the cost effectiveness of rehabilitation. The four-year rehabilitation time limit has encouraged some insurers to ignore rehabilitation in the hope that its direct costs will disappear. (163)

F29. Better coordination of medical and rehabilitation no fault resources is needed. More, not less, of the disability dollar should go to rehabilitation in those relatively few but serious cases in which rehabilitation would be of assistance to the injured person. (165)

F30. The present system lacks an effective dispute resolution mechanism. The net result is that in many cases rehabilitation is not undertaken or is undertaken so long after the accident as to limit its effectiveness. (165)

F31. The $140 per week maximum disability benefit which was established in 1978 is inadequate. (166)

F32. The insurance industry's performance in the delivery of disability benefits is in general abysmal. (166)

F33. There are gaps in the definition of those who are entitled to disability benefits. (167)

F34. The 30-day return-to-work relieving provision contained in Section B of the automobile insurance policy is too short. It provides a disincentive to returning to work. (169-170)

F35. There is no effective internal or external disciplinary mechanism which would provide insurers with an incentive to extend disability payments to insureds entitled to them without undue delay. (170)

F36. The funeral benefit is too low. (172)

F37. No fault coverage should not be limited by incorporating within it exclusions related to driving conduct; suicide and attempted suicide, however, are justifiable exclusions as they reflect intentional conduct. (173)

F38. Repair costs in Ontario compare favourably with those in other provinces. (175)

F39. Where after-market parts are available, competition between car maker parts and after-market parts has reduced prices by 25-40% depending on the type of repair involved. (177-178)

F40. Uninsured/unidentified motorist coverage does not belong in Section B of the policy. (181)

R20. The $200,000 minimum third party liability limits should continue. Those wishing to receive additional protection can do so by purchasing either additional third party liability or SEF 44 underinsured coverage or both on an optional basis. (143)

R21. The structure of the O.H.I.P. Bulk Subrogation Agreement should be examined to ensure that O.H.I.P. is paid whatever health care costs to which it is entitled as a result of motor vehicle related accidents. (150)

R22. The Insurance Act should be amended to require that all licensed automobile insurers be part of the 1978 O.H.I.P. Bulk Subrogation Agreement. (151)

R23. Consideration should be given to expanding the concept of the 1978 O.H.I.P. Bulk Subrogation Agreement to include other claims, (for example, medical malpractice), where O.H.I.P. subrogation is on a case-by-case basis. (151)

R24. Where future care costs are established at trial or by settlement, O.H.I.P.'s interest, if any, in the future care costs should be identified by the trial judge or by the settlement documentation. The present value of O.H.I.P.'s future care cost interest should be paid to O.H.I.P. (151-152)

R25. A study should be undertaken to determine if the first party underinsured and unidentified/uninsured coverages should be brought within the O.H.I.P. Agreement so that there will no longer be claim-by-claim subrogation in cases where those coverages are applicable. (152)

R26. Any insured and insurer entering into an agreement whereby the issued policy is a fronting policy or where any endorsement or other agreement results in the insured being a self-insurer, should be required to report the existence of such an arrangement and its terms to the Superintendent of Insurance. The insurer and the insured should jointly be required to pay the amount O.H.I.P. would otherwise have received had the special arrangement not been entered into. In the event that O.H.I.P., the insurer and insured cannot agree, the Superintendent of Insurance should have the authority, after consulting those involved, to deem a premium, if practical, in order to establish the base for the application of the O.H.I.P. bulk subrogation percentage factor. Alternatively, O.H.I.P. should have the right of subrogation on a case-by-case basis in those circumstances where the insured is a self-insurer. (153)

R27. Tighter controls should be imposed to ensure that cases which should be processed through the Workers' Compensation system are not processed through O.H.I.P. (153-154)

R28. Any other government ministries expending funds for those injured by accident should be required to determine and record the cause of the accident. (154)

R29. Chiropractors should be permitted to provide the certification of disability for disability benefit payment purposes. (169)

R30. The definition of spouse for the purpose of the no fault death benefit should be the same as the definition of spouse in the Family Law Act, 1986 (F.L.A.). (172)

R31. The expansion of appraisal centres should be encouraged. (176)

R32. All insurance companies should be required to establish quality and service guidelines for the use of aftermarket parts. Parts should be of O.E.M. quality and the quality should be guaranteed by both the supplier and the insurer. Consumers should be informed of the name of the manufacturer of the auto part being used in the repair. There should be severe penalties for the importation or sale of substandard, counterfeit or look-a-like auto parts. (179)

The Automobile Insurance Policy

F41. Taken as a whole, the standard form of automobile insurance policy is badly structured and incomprehensible. (134-135)

R33. A committee should be established to re-draft the standard automobile insurance policy. Drafting should not be left solely to lawyers or committees of the insurance industry. (184-185)

R34. The general definitions and provisions should be those which apply to the entire policy without exception. Definitions and provisions which apply to particular parts of the policy should be in the relevant part of the policy. (185)

R35. Exclusions relevant to each part of the policy should be contained in that part so that there is a clear understanding as to what coverage is excluded. (186)

R36. The policy should be structured as follows: (186)

Part 1: Third Party Liability

Part 2: No fault Benefits:

(i) medical and rehabilitation benefits

(ii) disability benefits

(iii) death and funeral benefits

(iv) other benefits

Part 3: Vehicle Damage:

(i) collision
(ii) comprehensive
(iii) specified perils
(iv) all perils

Part 4: Uninsured/Unidentified Motorist Coverage

Part 5: Supplementary Benefits respecting Accidents Occurring in Quebec

Part 6: Statutory Conditions, Policy Provisions and Definitions

(i) Statutory Conditions
(ii) General Provisions and Definitions

Part 7: Endorsement Coverage including SEF 44.

C. INSURANCE PRINCIPLES, THE CLASSIFICATION SYSTEM AND UNDERWRITING (Chapter 6)

F42. Premiums paid by an insured should reasonably reflect the degree of risk the insured imposes on the system. The grouping of risks with similar risk characteristics for the purpose of setting prices is a fundamental precept of any workable private voluntary insurance system. The classification of risks is fundamental to insurance. (189-190)

F43. The "good until proven otherwise" approach to premium rating is fundamentally flawed. Rating judgments have to be made before, not after, the event. (194)

F44. Cross-subsidization of a particular group or cell by others within the system runs counter to the competitive dynamics of the private sector delivery of insurance. (196)

F45. A classification system must be measured against a number of efficiency and equity criteria. Significant criteria include homogeneity, separation, reliability, acceptability and incentive value. (197-199)

F46. Young (under 25) drivers are involved in proportionately more accidents and more severe accidents than other drivers. (202)

F47. Young (under 25) males are involved in more frequent and more severe accidents than young females. (207-209)

F48. Substituting years licensed for age as a rating variable is imperfect in that:

(i) given the probable age of members of any classification cell as defined by years licensed, substituting years licensed for age will not in substance eliminate age as a rating criterion;

(ii) years licensed does not take into account data which consistently demonstrate that young newly-licensed drivers present a greater risk than older newly-licensed drivers.

(iii) Age (and sex) will not be ignored at the underwriting level. (212-213)

F49. Unlike age, sex in its own right is not predictive; however, eliminating sex as a rating factor and substituting kilometres driven will expose the system to increased verification costs which will be passed on to the consumer in the form of increased premiums; there is also a question as to the reliability of the substitute. (213)

F50. It is likely that increased premiums for young females will result from abandoning sex as a rating variable. (214)

F51. The predictive force of marital status as a rating factor is suspect and it has in any event become a socially unacceptable rating factor. (203)

F52. The introduction of a bonus/malus system on its own is neither workable nor consistent with the fundamental principles of insurance. Charging demonstrably unequal risks, equal premiums at entry violates basic insurance principles and leads to cross-subsidization. An insured's accident record and conviction record have a place in premium setting, but they cannot be used alone; they must be part of a sound classification system consistent with fundamental principles of insurance. (220)

F53. In order to operate with any degree of efficiency, a bonus/malus classification system requires complete exchange of information among insurers. (223)

F54. Injustices can occur in a bonus/malus system because malus points are triggered by claims

against the policy quite apart from the identity of the driver of the insured automobile at the time of an accident. (223-224)

F55. Underwriting abuses which existed through 1986 and into 1987, in some respects, continue to exist in the Ontario automobile insurance industry. (237)

F56. Motorcycles present a problem from a standpoint of first party no fault coverage. Those injured on motorcycles being relatively unprotected tend to suffer more severe injuries than those injured in automobile accidents; further the owner/driver population of motorcyclists tends to be young. (237-238)

F57. Taxis present a unique premium problem; the root cause of the taxi industry's premium problems is high loss costs. Even at the high current premium levels Ontario motorists are subsidizing taxis and taxi operators outside of Toronto are subsidizing taxi operators located in Toronto. (239-240)

R37. Marital status should no longer be used by the automobile insurance industry as a rating factor. (203)

R38. The proposed classification which eliminates age, sex and marital status as rating factors should be discussed and evaluated outside the parameters of the committee established to create it. The impact of the system on the premiums consumers will be required to pay should be disclosed and discussed. (217)

R39. The resort to the number of insurers any applicant for insurance has had over any particular timeframe as an underwriting criterion should be prohibited and deemed an unfair underwriting practice. (230)

R40. Named occasional drivers should be excluded from automobile insurance coverage in circumstances where both the named insured and the occasional driver have acknowledged in writing that coverage is not sought and is not to be extended to the named occasional driver. (231)

R41. A new offence should be created so as to penalize the named insured in those cases where the named insured has given consent to the excluded occasional driver's use of the insured vehicle. (232)

R42. A new offence, short of theft and in addition to driving without insurance, should be established to penalize an excluded occasional driver who has driven the insured's car with or without consent. (232)

R43. The loss experience of the Facility Association should be continually monitored; steps should be taken to attempt to identify those clean risk drivers who demonstrably do not belong in the Facility Association from those risks, clean or otherwise, that the regular market cannot reasonably be expected to underwrite. (234-235) See also R141.

R44. The basic premium rating for three-wheel all terrain vehicles, four-wheel all terrain vehicles and other off-road vehicles such as snowmobiles should be examined as part of structuring the new classification system. (239)

R45. The recommendations contained in the 1987 Report of the Metropolitan Licensing Commission concerning the taxi industry should generally be endorsed. (241)

R46. There should be better driver education and control, possibly through the use of incentives, for taxi drivers. (241)

D. LOSS COSTS AND PREMIUMS (Chapter 7)

Loss Costs

F58. Property damage loss costs per vehicle have remained relatively stable. (248)

F59. There has been a steady increase in bodily injury loss costs since 1982. (248)

F60. The property damage component of third party liability coverage has remained relatively stable. Accident benefit loss costs have increased but are under control. The loss cost problem area is in bodily injury claims. (250)

F61. Non-pecuniary general damages represent the single most significant component of damages regardless of the size of the claim. As the size of the claim

increases, the proportion of non-pecuniary general damages decreases. In smaller claims, non-pecuniary general damages account for approximately 70% of the claims settlement dollar. For claims above $75,000, non-pecuniary general damages account for approximately 25% of the claims settlement dollar. (262)

F62. Party-and-party costs paid to counsel for injured claimants account for 11% of the claims dollar. Prejudgment interest accounts for 10% of the claims dollar and F.L.A. claims account for approximately 5% of the claims dollar. (262-263)

F63. There are a number of explanations for the increase in bodily injury claims costs. These include:

(i) economic loss increases in times of economic prosperity; (269)

(ii) economic prosperity leads to more driving. As traffic density increases, accident frequency increases; (269)

(iii) since 1980, the discount rate has been established by statute at 2.5%; in 1978 a 7% discount rate was commonly used; (270)

(iv) the 1978 decisions of the Supreme Court of Canada in the Trilogy have forced trial judges and juries to break down damage assessments into reasonable constituent parts. This breakdown has resulted in a higher calculation of economic loss; (270)

(v) injured claimants have increasingly retained counsel to represent their interests. The involvement of counsel on balance will result

in an increase in the settlement value of a claim; (270)

(vi) lawyers are increasingly inventive in their development of evidence to establish economic loss which in turn has increased economic loss damage assessments; (271)

(vii) experts are more capable of giving evidence in a manner that is convincing to trial courts and on balance this has resulted in an increase in damages; (271)

(viii) in cases where future care costs are significant or in major fatal accident cases gross-up significantly increases claims costs; (272)

(ix) health care advances have resulted in badly injured persons surviving at great expense over a significant, albeit reduced, life expectancy; (272)

(x) the pre-trial process has generally worked to increase the value of claims; (272)

(xi) Family Law Reform Act (F.L.R.A.) and F.L.A. claims have increased damages; however, recent increases in bodily injury claims costs cannot be attributed to F.L.A. claims; (273)

(xii) prejudgment interest has had a significant impact on the costs of bodily injury claims; (273)

(xiii) while judicial generosity is overplayed by insurers, there is no doubt that economic loss has increased and the judicial treatment of it has been more generous, particularly in the case of future care costs. This has increased bodily injury costs. However, in the last few years, trial judges and juries have become

more moderate in their treatment of non-pecuniary compensation, particularly in respect of F.L.A. claims. (274)

Premiums

F64. Although third party liability/property damage premiums increased substantially in 1985 and 1986, the 1986 level was still less than the premium level in 1977. (277)

F65. The accident benefit premium line has been relatively unstable but the variations from year to year have not been large. In constant dollars, accident benefit premiums in 1986 were marginally lower than accident benefit premiums in 1976 and about the same as accident benefit premiums in 1981. (277)

F66. Section C collision premiums in 1986 were substantially lower than their high point in 1977 and about the same as they were in 1983. (277)

F67. Section C comprehensive premiums have increased substantially since 1975. (277)

F68. The composite all coverages premium trend follows the same general path as third party liability premiums. Even after the substantial 1985/1986 increase, the premiums were still less than premiums in 1977, when measured in constant 1981 dollars. (278)

Loss Costs and Premiums

F69. The bodily injury/property damage cost premium gap was at its widest in 1977 when premiums significantly exceeded costs and in 1985 when loss costs significantly exceeded premiums. (279)

F70. Reserves should be discounted in order to provide a realistic assessment of an insurer's performance. (283)

F71. The insurance industry took no real account at any time and particularly in the early 1980s of the probable impact of prejudgment interest and F.L.R.A. claims. Insurers also did not take reasonable account of the probability that claims costs would necessarily increase once the recession of the early 1980s ended and relative prosperity returned. (285)

F72. Given bodily injury loss cost trends, premiums which should have been increased earlier and more gradually, were increased in 1985/86. By 1985/86 the premium increase was probably justified, but given its sudden implementation consumer complaints were to be expected. (283-285)

F73. The property damage part of the third party liability coverage presents no real cost problem and should not be the source of a premium concern. (295)

F74. Accident benefit coverage is an area where there has been an increase in average claims costs;

however, there is not a cost/premium problem for this coverage. (295)

F75. There is no cost/premium problem with the optional collision and comprehensive coverage lines.

F76. Bodily injury frequency has stabilized. (296)

F77. As long as bodily injury average loss costs per car continue to increase, premiums will increase. (296)

F78. The 1985/86 bodily injury/property damage premium increases brought premiums and loss costs into a semblance of balance. There are current indications of moderation within the system at the third party level. (296-297)

E. COURT PROCEEDINGS (Chapter 9)

Pleadings

F79. In motor vehicle accident litigation, pleadings are unnecessarily complex; pleadings particularizing negligence are of no real benefit. (344)

R47. The Rules of Civil Procedure should be amended to eliminate the requirement that pleadings in motor vehicle accident litigation particularize allegations of negligence. (344)

R48. The Rules of Civil Procedure should provide that the Statement of Claim set out the damages claimed for both economic and non-economic loss for each plaintiff and a statement as to the nature of the

plaintiff's injuries. The Statement of Defence should briefly set out the defendant's position on both liability and damages. (344-345)

R49. Trial judges should be given specific authority to impose cost penalties on solicitors making unsupported allegations in pleadings. (345)

Pre-trials

R50. All actions should be pre-tried and should not be placed on a trial list until certified as ready by the pre-trial judge or, in the absence of the pre-trial judge, by another judge of the court. (346)

R51. In a motor vehicle accident case when damages are in issue, pre-trial documentation should include:

(a) all medical reports of any doctor whose evidence will be tendered at trial either in the form of viva voce evidence or by the filing of a medical report;
(b) any other experts' reports to be relied upon; and
(c) a breakdown of each party's position with respect to all aspects of economic loss. (346)

R52. Where possible, the parties themselves should attend the pre-trial, unless the defendant is insured and policy limits are not a relevant issue. (346)

R53. Actions should not be set down for pre-trial until counsel setting the action down has specifically certified that discoveries have been completed and the action is ready for trial. The onus should be on counsel to arrange a pre-trial. (366)

R54. All Provincial Courts (Civil Division) should assign duty counsel to assist all those who require help at the pre-trial. Duty counsel at the pre-trial should ensure that plaintiffs, in particular, have filed Offers to Settle and that required evidence (such as medical reports) is available. Medical evidence in the Provincial Court (Civil Division) should be in the form of a report unless leave is granted to have a medical practitioner give viva voce evidence. (356-357)

R55. The Ministry of the Attorney General's data collection procedures should be expanded, in order to capture data relating to the number and the time consumed by pre-trials as related to the same classification of cases (including motor vehicle cases) on which data are now recorded. (366-367)

Medical and Other Experts' Reports

F80. The dominant objectives relating to the production and disclosure of medical and other experts' reports should be to promote fair trials, early settlement and reduce the cost of litigation. (351)

R56. Section 52 of the Ontario Evidence Act should be amended to bring within its provisions the reports of all health professionals including dentists,

chiropractors, psychologists, physiotherapists and rehabilitators. (351)

R57. *Section 52 of the Evidence Act should be amended to require that any party intending to call a doctor or other health professional as a witness be required to produce all reports of that witness. (353)*

R58. *Section 52(2) of the Evidence Act should be amended to require explicitly that a party intending to file a medical report produce it to the other side. (353)*

R59. *Section 52(3) of the Evidence Act should be amended to provide that doctors who have medically examined any party and doctors who are involved as consultants only, are both subject to the same rules with respect to medical reports and a doctor's right to give viva voce evidence at trial. (353)*

R60. *Greater use should be made of Rule 53.02(1). (352)*

R61. *Rule 50.05 of the Rules of Civil Procedure should be amended to require that medical reports and reports of other experts be produced both for the pre-trial judge and other parties seven days before the pre-trial. (352)*

R62. *The trial judge should have the discretion to permit an expert's report to be filed as an exhibit in jury and non-jury trials even if the expert will be called to give viva voce testimony at trial.*

Offers to Settle

R63. The Rules of Civil Procedure should be amended to require a plaintiff to make an offer to settle within 7 to 10 days after a pre-trial. (360)

R64. Rule 57.01(1) of the Rules of Civil Procedure should be amended to add as a factor the court may consider on the question of costs, the failure of a successful party to make an offer to settle. (360)

Trials

F81. The impact of the recommendation of the Ontario Courts Inquiry as to costs in the Provincial Court (Civil Division) is that a 3% savings may be effected. (356)

F82. Motor vehicle accident cases do not consume an inordinate amount of court time because the vast majority are concluded by settlement, not trial. (383)

F83. In particular, over the period 1982-1985:

(a) The vast majority of all motor vehicle accident claims were resolved without any action being commenced.

(b) Actions were commenced in less than 50% of bodily injury claims.

(c) Even when an action was commenced, more than two-thirds of the actions were resolved before the action was set down for trial.

(d) Between 2% and 3% of bodily injury claims went to trial. (364-365)

F84. The number of motor vehicle actions commenced in the Supreme Court of Ontario declined during the period 1982-1985; the number of Supreme Court motor vehicle actions set down for both jury and non-jury trial remained more or less stable in that period. (367)

F85. There has been a significant increase in the number of motor vehicle jury actions in both Supreme and District Courts. The increase in the delivery of a jury notice is most significant in Toronto in both courts but particularly so in Supreme Court motor vehicle cases. (375)

F86. Most jury notices are served by defendants. (375)

F87. There has been a significant reduction in the percentage of Supreme Court motor vehicle non-jury actions tried, a reduction which is likely attributable to the increasing impact of the pre-trial in promoting settlement. (375)

F88. In the District Court a greater percentage of non-jury motor vehicle accident actions went to trial than jury actions. (376)

F89. There has been a significant increase in the percentage of motor vehicle accident cases settled before trial in the Supreme Court in the period 1985-1986 compared to the period 1979-1980. (376)

F90. There was a significant increase in the number of non-jury motor vehicle accident cases settled before trial in the District Court in the period 1985-86 compared to the period 1979-80. (376)

R65. The Rules of Civil Procedure should be amended so as to create two separate lists as follows:

(i) a list of cases set down for pre-trial; and
(ii) a list of cases ready to be tried. (366)

R66. The list of cases ready for pre-trial should consist of cases in which counsel has certified that discoveries have been held and the case is ready to be pre-tried. (366)

R67. The cases-ready-to-be-tried list should consist of pre-tried cases which have been certified as ready for trial by the pre-trial judge. (366)

R68. The Courts of Justice Act should be amended to provide that in jury cases, trial judges have a discretion to express an opinion to the jury as to a range of compensation for both pecuniary and non-pecuniary damages. (354)

R69. Trial judges should give greater consideration to making orders in the form of directions to the Assessment Officer with respect to disbursements for experts in connection with motor vehicle accident litigation. (359)

R70. The Ministry of the Attorney General should examine the cost of civil jury actions and should consider

increasing the fee paid for setting an action down for jury trial. (376-377)

F. COMPENSATION ISSUES (Chapter 10)

Family Law Claims

F91. The statistical evidence does not suggest excessive costs associated with family law claims, nor does it suggest that the assertion of trivial claims by numerous relatives for damages for guidance, care and companionship is widespread. (390)

F92. Recent statutory procedural changes and decisions of the Ontario Court of Appeal will reduce both the number of family law claimants and amount of awards for loss of guidance, care and companionship. As a result, changes to the F.L.A. cannot be justified on a cost basis. (390-392)

F93. The principles underlying the awarding or compensation for guidance, care and companionship as set forth in the F.L.A. are on balance to be preferred to those underlying the recent recommendation of the Ontario Law Reform Commission. (394-395)

R71. Section 61(2)(e) of the F.L.A., which provides compensation for the loss of guidance, care and companionship, should not be amended. Specifically, the recommendation of the Ontario Law Reform Commission that claims by dependants for loss of guidance, care and companionship be abolished, should not be implemented. (393-394)

Prejudgment Interest

F94. Compensation of the victim should be the main object of prejudgment interest. The interest rate should be neutral. (400)

F95. When the full prejudgment interest rate is awarded on the non-pecuniary damage portion of an award, the plaintiff is overcompensated. (407)

R72. The Courts of Justice Act should be amended to provide that in the case of both liquidated and unliquidated damages, prejudgment interest on personal injury awards should be calculated from the date the cause of action arose. (401)

R73. Prejudgment interest payable in circumstances where SEF 44 underinsured coverage is responding to the claim, should run from the date of loss rather than from the date of notification. (401)

R74. Section 138 of the Courts of Justice Act should be amended to permit compound interest calculated at quarterly intervals to be awarded. (402)

R75. Section 137(1)(d) of the Courts of Justice Act should be amended to provide that the prejudgment interest rate be the bank rate. Section 137(1)(d) should also provide that the prejudgment interest rate be adjusted quarterly and that a fractional rate be rounded either up or down to the nearest tenth of a point. (402-403)

R76. *Section 138 of the Courts of Justice Act should be amended to provide that prejudgment interest on non-pecuniary general damages bear interest at the real rate of return. If a specified rate is used, it should be in the range of 3.5 to 4% with provision for a periodic review by the Rules Committee. (410)*

Discount Rate

R77. *A mechanism should be established to review from time to time, the appropriateness of the discount rate provided for in Rule 53.09 of the Rules of Civil Procedure. (413)*

Gross-Up and Structured Judgments

F96. A structured settlement has certain identifiable advantages over a pure lump sum, future loss payment which is to be invested at a predetermined interest rate. The advantages are most obvious for future care costs in injury cases and pecuniary loss in fatal accident cases. (422-424)

R78. *Section 129 of the Courts of Justice Act should be amended to provide for mandatory structured judgments at the discretion of the trial judge, for future care costs in injury cases and for pecuniary loss in fatal accident cases. (424)*

R79. *Once the trial judge in the exercise of his discretion imposes a structured judgment, the parties should be given a reasonable but short period of time (for example 14 days) to consult structured settlement consultants or life insurers*

and then make submissions to the trial judge as to the form of the structured judgment. (425)

R80. To the extent a gross-up calculation is still required in jury trials, that calculation should be made by the trial judge (rather than the jury), after the jury has made findings of fact as to compensation which would attract gross-up. (425)

R81. If a gross-up calculation is still required, a sub-committee of the Rules Committee should be established to develop a uniform method for the gross-up calculation to be used in all relevant cases. (425-426)

Collateral Source Rule

F97. Inquiry claims survey data demonstrate that those injured in motor vehicle accidents who have collateral sources of income are receiving 56% more than their tort law-based wage loss entitlement. This results in aggregate overcompensation among all injured in motor vehicle accidents of 17%. (433)

F98. It is reasonable to conclude that abolition of the collateral source rule would have an uncertain but demonstrable effect in reducing claims frequency.

F99. The collateral source rule as presently applied in Ontario is wasteful in practice and cannot be justified in principle. (438)

F100. The continuation of the collateral source rule cannot be justified on deterrence grounds.

F101. Many sources of collateral payments do not exercise subrogation rights. (439)

F102. For cost and public relations-related reasons it is unlikely that subrogation rights will be exercised and it is therefore inappropriate to develop a model for eliminating overcompensation caused by the collateral source rule that is premised on subrogation. (439)

R82. The Government of Ontario should enact legislation which provides:

(a) that the collateral source rule be abolished;

(b) that where an injured person receives collateral benefits in the nature of indemnity payments from either public or private sources, the amount of such payments (subject to income tax where appropriate) be deducted from the relevant components of a tort award made to the injured person so that there will be no overcompensation. (442-443)

R83. Taxable collateral source payments should be deducted net of tax. A flat 20% tax factor should be applied to reduce the collateral source offset. (443-444)

R84. Loss of future income should be established and paid without collateral source offset but the claimant should be required to hold future collateral source payments in trust for the third party insurer net of tax where applicable. (444)

R85. Both the Government of Ontario and the Government of Canada should conduct a review of their

respective programs which provide income assistance in the event of an accident in order to determine:

(a) the amount of monies paid to persons injured as a result of motor vehicle accidents; and

(b) the extent to which rights of subrogation in respect of these payments are being exercised or are feasible. (443)

G. RECOMMENDED SYSTEM OF COMPENSATION (Chapter 12)

F103. Because automobile insurance is compulsory, it must be made available at a price consistent with sound insurance principles. (513)

F104. Alternative compensation systems should be assessed against the following reasonable evaluation criteria: compensation, rehabilitation, cost efficiency, incentive/deterrence, fairness, insurance considerations, constitutionality. (515-517)

F105. A comprehensive compensation plan for those injured by accident or for the disabled is not a viable option, but the design of a compensation scheme for motor vehicle accidents should take into account the prospect of the eventual development of a comprehensive compensation plan. (517)

F106. From the standpoint of the compensation criterion, pure no fault and threshold no fault are superior to the tort system. (519)

F107. Rehabilitation is an essential objective of any compensation system and it cannot be realistically achieved through the tort system. Because no fault

compensation is delivered on a first party basis and because rehabilitation benefits must be made available without undue delay, the rehabilitation criterion is better served by no fault than by tort law. (520-521)

F108. Transaction costs can be reduced in a pure no fault plan. The reduction will likely be in the area of 5% of earned premiums. To that extent, pure no fault is more efficient than the current third party compensation system. It is doubtful there would be any significant reduction in transaction costs in threshold no fault. There is, hence, no cost efficiency basis on which to proceed to threshold no fault. (528)

F109. In a no fault system, if premiums are not to be increased, the funding for increased first party benefits can only be obtained by systematically reducing or eliminating existing rights to non-pecuniary compensation. (530)

F110. The tort system still performs some modest deterrent function in the motor vehicle context, even if its impact is not empirically demonstrable. (540)

F111. Even if the concepts of fault and responsibility exert no positive deterrence influence the introduction of a no fault compensation plan may well have a modest adverse effect on driver care. (542)

F112. The introduction of no fault in Quebec did have some unquantifiable impact on the Quebec motor vehicle accident rate, but the no fault impact was

small compared to the impact of compulsory insurance and flat premium rating. (538)

F113. Tort law's capacity for fairness and justice should not be ignored. The moral neutrality of some motor vehicle accidents cannot withstand even anecdotal analysis. The public's expectations and sense of fairness would be offended if the more seriously injured were not permitted to have access to compensation for both economic and non-economic loss assessed on an individual case-by-case basis. The public's sense of fairness will not be satisfied if fault is left to be dealt with solely through the criminal justice system and the premium rating system. (545-549)

F114. The insurance industry's flexibility is more than sufficient to deliver benefits and compensation in any reasonable compensation scheme. (550)

F115. The threshold proposed by the I.B.C. in its submission to the Inquiry is inappropriate.

F116. A prevailing shortcoming of the insurance industry at the claims level is in the delivery of first party benefits. It is unrealistic to conclude that upon conversion to a form of no fault compensation plan, claims-related dealings between insurer and insured will be substantially improved. (561)

F117. Establishing a no fault automobile insurance compensation scheme as a first step to a more comprehensive no fault compensation plan may make it less likely, not more likely, that a more comprehensive compensation plan could eventually be implemented. (564-565)

F118. The efficiency assumptions made by the Ontario Task Force on Insurance are in error. A no fault system in which policies are sold on an individual basis cannot return 80¢ to 90¢ of the premium dollar to claimants. (565)

F119. A motor vehicle accident compensation system should deal humanely with all those who are injured and provide reasonably generous rehabilitation and long-term care benefits on a no fault basis, while at the same time preserving a compensation distinction between those who cause accidents and those who do not. (567)

F120. Threshold no fault should be rejected because it is relatively inefficient and unnecessarily arbitrary. There will either be no or minimal savings on transaction costs in threshold no fault. (567)

F121. Pure no fault should be rejected on fairness and deterrence grounds and because it is manifest that few seem to want it. While there are clear benefits to pure no fault compensation from a cost efficiency standpoint, appropriate social policy cannot be judged solely on a cost basis. (568)

F122. While continued use of the tort system on its own cannot be justified on compensation grounds, this does not require abandonment of the tort system.

F123. There is no valid reason why the provision of humane no fault benefits and tort law cannot co-exist. The preservation of fault-based access to individualized compensation accords with the public's sense of what is right and, in a modest

way, may achieve some deterrence benefits. The criticism of the tort system on compensation grounds is answered by the availability of fair and comprehensive no fault benefits. (568-569)

F124. The legitimacy of the co-existence of no fault and tort requires first that there be a substantial expansion of the quantum of no fault benefits and the eligibility criteria for these benefits; and second, that the compensation plan be capable of being delivered through the automobile insurance system at a reasonable cost. (569)

F125. The quantum of the no fault income replacement benefit must be increased to provide economic stability for those injured in motor vehicle accidents; it is, however, inappropriate to establish an inordinately high income replacement benefit bearing in mind that it is compulsory for Ontario's drivers to buy this coverage. (574)

F126. Those injured in motor vehicle accidents should not have access to no fault benefits significantly higher or lower than the benefits available to those injured in the workplace. (575)

F127. A seven-day waiting period before the receipt of no fault benefits will eliminate the incentive to stay off work now built into the system and will also reduce transaction costs for short-term cases.

F128. The death benefit should not be linked to the deceased's income, but should rather provide some reasonable short-term financial assistance to survivors, responsive to the simple recognition of

the value of life. The death benefit should be modest, but not insignificant. (580)

F129. If the proposed changes are implemented, Ontario's motorists will be the beneficiaries of substantially increased no fault benefits at moderately reduced cost and without the collateral sacrifice of any right to individual compensation under tort law. Total cost savings should be approximately $65 million. Overall, the proposed changes will result in an estimated loss cost decrease of $12.52 per car. The estimated cost reduction will also have a ripple effect which will serve to further reduce costs and premiums. Premium decreases should at least equal cost savings. (585-587)

F130. The calculation of income loss, particularly past income loss, on a pre-tax basis should be considered. If past income loss were dealt with on an after-tax basis, cost savings would be about $6 per car. If future income loss were dealt with on an after-tax basis, there would be further cost savings of about $4 per car. If all income loss were assessed on an after-tax basis, the abolition of the collateral source rule would result in a further savings of approximately $7 per car. (589)

F131. The proposed changes will result in a per motorcycle cost increase of approximately $31 with subrogation and $85 without subrogation. (590)

F132. The proposed changes will result in a cost savings of approximately $24 per commercial vehicle (ordinary truck). (593)

F133. On any reasonable cost benefit analysis, truly small cases do not fare well in the tort system. A fair threshold should focus on cases that legitimately involve injury and disability of a minor nature. Rather than denying the less seriously injured any compensation for pain and suffering and loss of enjoyment of life, the entitlement to non-pecuniary general damages of the less seriously injured should be limited or capped. (597-598)

R86. A comprehensive compensation plan for accidental injuries or beyond that, a universal disability program should be given further consideration at the federal and provincial levels. (517-518)

No Fault Benefits (Accident Benefits)

R87. The standard form of automobile insurance policy should be expanded to provide no fault accident benefits without exclusions related to driving conduct. (570)

R88. The rehabilitation benefit should be increased from $25,000 to $500,000 per claim. The time limit should be increased from 4 years to 10 years, or 20 years less the victim's age, whichever is longer. (571)

R89. Rehabilitation should be expansively and clearly defined so as to remove doubt as to the first party insurers' obligation to fund physical and vocational rehabilitation. (571)

R90. Rehabilitation should be paid for at the first party level, not on an expense-incurred-only basis,

but rather by giving the claimant, the claimant's medical advisors and the claimant's medical rehabilitation counsellors the benefit of the doubt. (572)

R91. *Long-term care should be separated from rehabilitation and fixed at $500,000. The family of the injured person should not be excluded from long-term care compensation entitlement. Long-term care benefits should be no greater than the monthly cost of group residence which might reasonably accommodate the insured's needs having in mind the nature of the injuries and any other relevant factors. (573)*

R92. *The disability benefit for the employed should be based upon 80% of the claimant's gross income and should be increased from $140 per week to a maximum of $450 per week. Except for U.I.C. benefits, disability benefits should be non-primary. (574-575)*

R93. *Disability benefits for the employed should not be paid for the first seven days. (576)*

R94. *Disability benefits for the employed should extend for life. (576)*

R95. *Eligibility for disability benefits for the deemed to be employed should commence at age 16 not age 18, and terminate at age 65. The deemed to be employed disability benefit should be subject to a 60-day waiting period. (577-578)*

R96. *Once eligible for disability benefits, an insured*

deemed to be employed should be entitled to the same benefit as the employed. (578)

R97. A student should receive no fault compensation as follows:

(a) if in elementary school, $1,000 for each school year lost;

(b) if in secondary school, $2,000 for each school year lost;

(c) if in college or university, $4,000 for each year of education lost to a cumulative maximum of three years or, if a semester is lost, the appropriate part of $4,000 according to the university's semester system;

(d) $340 per week at age 19 if disabled and not attending school. (579-580)

R98. The death benefit should be increased to $25,000 for the death of the head of the household or the death of the spouse of the head of the household. An additional $10,000 should be paid for each dependant of the head of the household or spouse. (581)

R99. The funeral benefit should be increased to $3,000. (581)

R100. There should be a home care benefit in the amount of $50 per week maximum payable on a reasonable expense incurred basis. There should be a seven-day waiting period for this benefit. The standard of disability should be the same as for regular disability benefits. (582)

R101. There should be a child care benefit in the amount

of $200 per week. An additional $50 per child or dependant per week should be payable to a maximum of $350 per week. The benefit should be paid for two weeks without presentation of receipts and thereafter in response to reasonable and proven expenses to the maximum. There should be no family member exclusion. The standard of disability should be the same as for regular disability benefits. (582)

R102. *All accident benefits other than the death benefit should be indexed once a year to the annual Consumer Price Index subject to a cumulative maximum of twice the stipulated benefit. (593)*

Related Matters

R103. *Because the expanded no fault benefits will provide a relatively severe premium problem for motorcycles, subrogation for motorcycles should be permitted. (590)*

R104. *Accident benefit claims forms should be common to all licensed insurers. The forms should be simplified and colour coded so that one form is not confused with another. (594)*

R105. *Those in hospital for more than seven days should be paid the first two weeks of accident benefits entitlement without a medical report unless there are circumstances which clearly and unequivocally suggest that payment is inappropriate. (594)*

R106. *Adjusters should be given specific disability benefit authority in the amount of $2,000. (594)*

R107. Claimants should pay for the cost of obtaining reasonably required disability benefit medical report forms for the first three months of disability and thereafter the cost of these short medical reports should be borne by the insurer. (594)

R108. Insurers and the medical profession should try to reach an agreement on an acceptable fair fee for disability benefit medical reports; alternatively a reasonable fee should be built into the O.H.I.P. fee schedule. (594-595)

R109. Section B forms should be delivered immediately to the injured insured if the insured is in hospital and mailed or delivered to the insured if the insured is not in hospital. The onus of delivery of the required forms should be on the insurer. Hospitals (particularly emergency wards) should be provided with no fault medical forms and if practicable the other forms as well. (595)

R110. Efforts should be made to coordinate the automobile insurance no fault forms with those of Workers' Compensation, U.I.C., Canada Pension Plan and long-term disability carriers. (595)

R111. The Insurance Act should be amended to provide the insured's physician or the insured's treating chiropractor with the required authority to complete the disability benefit medical form and remit it to the insured's insurer. (595)

R112. The calculation of the disability benefit should be made available to the insured. (596)

R113. The 30-day return to work provision contained in the automobile insurance policy should be increased to 90 days. (596)

R114. Disability benefits should be paid within 15 days of the insurer's receipt of the required forms. (596)

R115. If a form of no fault compensation plan is desired, consideration should be given to a modified threshold plan in which non-pecuniary general damages in less serious cases (as defined by a moderate verbal threshold) are capped with the result that in those less serious cases which do not meet the defined threshold, non-pecuniary general damages will be limited to a maximum of $3,000. (598)

H. OTHER INSURANCE AND CONSUMER ISSUES (Chapter 13)

Catastrophic Claims Fund

R116. There is no need to establish a Catastrophic Claims Fund in Ontario. (601)

Consumer Information

R117. Typical premiums or premiums set by the Board should be publicized and explained. (602)

R118. Consumers should have access to claims information including:

(a) the insured's entitlement to no fault benefits and the quantum of those benefits;

(b) procedures to be followed in asserting third party claims;

(c) *the availability of dispute resolution mechanisms;*

(d) *the availability of social programmes which might be of relevance to a person injured in a motor vehicle accident;*

(e) *the consumer's right to challenge legal fees through the assessment process in those cases where an insured has retained a lawyer;*

(f) *particulars of any relevant limitation periods. (603)*

R119. *The provision of information to consumers should be dealt with through the office of the Superintendent of Insurance. The Superintendent's office should be expanded to accommodate the required dissemination of information. (603)*

Claims and Underwriting Practices

R120. *The Ontario Government should enact unfair claims practices legislation. Claims standards which should be the subject of regulation include:*

(a) *an injured insured should be provided with all required no fault documentation within seven days of the accident;*

(b) *no fault benefits should be paid within 15 days of the insurer's receipt of required documentation;*

(c) *no fault claims forms should include instructions as to processing the claim and the telephone number of a named insurance company representative;*

(d) *if an insurer is reasonably required to continue investigating a claim beyond the 15-day period, where practicable the insurer*

should notify its insured of that fact and provide information as to the expected date when the investigation will be completed;

(e) *if a claim is denied on the basis of a specific policy provision, condition or exclusion, the insurer should be required to give specific information as to the provision, condition or exclusion being relied upon;*

(f) *payment of any first party benefits should be accompanied by an explanation of what the payment is for;*

(g) *no insurer should be permitted to refuse to pay all or part of any first or third party claim where there is no reasonable good faith dispute as to the insured's or the claimant's entitlement;*

(h) *no insurer should require an insured or claimant to sign a release extending beyond the subject matter giving rise to the claim payment;*

(i) *if a first party claim is denied on the basis of a medical opinion secured by the insurer, the insurer should be given a copy of the medical report. Insurers should be prohibited from denying first party claims based on verbal medical reports;*

(j) *an insurer requiring a medical examination of an insured should be required to continue first party benefit payments pending the completion of the medical examination and the insurer's receipt of a medical report;*

(k) *insurers should be obliged to fund reasonable rehabilitation if there is credible medical evidence and in appropriate circumstances the evidence of a rehabilitation consultant supporting the proposed rehabilitation. If an*

insured refuses to undertake or continue rehabilitation that has been recommended by his own medical advisor or the insurer's medical advisor, the insurer's obligation to pay disability benefits should continue until the issue has been dealt with through dispute resolution. (604-607)

R121. *The Superintendent of Insurance should be given power to adopt rules to ensure the prompt, fair and honest processing of claims and complaints. (607)*

R122. *Insurers should face the prospect of reasonable financial penalties to a maximum of $10,000 for unacceptable claims and underwriting practices. Hearings dealing with any alleged unfair claims or underwriting practice should be conducted by the Superintendent of Insurance or the Superintendent's nominee. The hearings should be relatively informal and subject to appeal only by way of judicial review. (607)*

R123. *An insured who has received delayed or no payment of a first party benefit entitlement should be then entitled to interest at twice the prime rate. (607)*

R124. *The Superintendent of Insurance should have jurisdiction to respond to proved underwriting abuses and to impose appropriate penalties. (608)*

Dispute Resolution

R125. *As a first step to resolving disputes concerning accident benefits, the I.B.C.'s review committee proposal should be accepted. Every insurer should designate one representative to be responsible for*

review of no fault benefit payment decisions. The review committee decision will be binding on the insurer but not the insured. (609)

R126. In the event an insured is dissatisfied with the decision of a review committee the insured should have access to arbitration or the courts by a de novo hearing. (604)

R127. The Bar and the insurance industry after joint consultation should establish a regionalized roster of acceptable arbitrators in order to deal with first party automobile insurance policy disputes. (609)

R128. Serious consideration ought to be given to establishing an arbitration division within the court structure. (610)

Uninsured Drivers

R129. The fine for driving without insurance coverage should be increased. Anyone convicted of driving without insurance should be exposed to an automatic licence suspension in addition to a fine. Driving privileges should not be restored until the offender has filed proof of financial responsibility. (612)

Information Systems

R130. The Ministry of Transportation and Communications should act immediately to transfer driver records to computer. The information should be available on-line to any licensed Ontario automobile insurer for a yearly fee based on market share. (615)

R131. A cooperative information network should be established between the Registrar of Motor Vehicles and licensed Ontario automobile insurers to permit the immediate verification of automobile insurance coverage. (615-616)

R132. All licensed Ontario automobile insurers should be required to be part of an information system and therefore should be required to submit claims histories of their insureds to the database; all insurers should have access to that information. (616)

I. CONSTITUTIONAL CONSIDERATIONS (Chapter 14)

F134. The province, by virtue of section 92(13) of the Constitution Act, 1867 has legislative authority to create, modify or abrogate causes of action in tort; equally a province has legislative authority in relation to automobile insurance and the authority to enact a no fault compensation plan. (619)

F135. The administration of a no fault motor vehicle accident plan by an administrative agency rather than the courts does not offend section 96 of the Constitution Act. (619)

F136. Replacing the right to sue in tort with a no fault plan does not infringe section 7 of the Canadian Charter of Rights and Freedoms. (621-623)

F137. An automobile no fault plan does not infringe section 15 of the Charter. (630-631)

F138. Threshold schemes are constitutionally more vulnerable than pure no fault schemes but a reasonable threshold scheme would on balance not infringe section 15 of the Charter. (639)

F139. Even if a no fault or threshold scheme infringed either section 7 or section 15 of the Charter they would be justified under section 1 of the Charter. (640-641)

F140. While the use of age 65 as a cut-off point for eligibility for no fault automobile disability benefits may be vulnerable to a challenge under section 15 of the Charter, it would likely be justified under section 1. (642)

F141. It would not offend section 15 of the Charter to distinguish between those actively employed and those deemed to be employed by providing an age 65 termination date for disability benefit eligibility for the latter. (643)

F142. The age 18 commencement date for those deemed to be employed likely infringes section 15 of the Charter and cannot be justified under section 1. (643)

F143. The use of age as a premium rating variable is more likely to survive a Charter challenge than the use of sex. (648)

R133. Further consideration ought to be given to the extent to which neutral classification factors can be developed which are accurate substitutes for age or sex. (650)

J. PUBLIC OR PRIVATE DELIVERY OF AUTOMOBILE INSURANCE (Chapter 15)

F144. Interprovincial premium comparisons are at best unhelpful and at worst misleading in assessing the comparative cost efficiency of public and private delivery systems. (671)

F145. The simple classification systems used in the public plans result in extensive cross-subsidization of high risk drivers by low risk drivers. (667)

F146. Cross-subsidization does not occur in Ontario's private sector competitive delivery system except in the residual market (the Facility Association). (666)

F147. A decision to nationalize Ontario's automobile insurance industry would have the following potential consequences:

(a) There would be very significant financial and organizational implementation requirements.

(b) Some of those now employed in the insurance industry would lose their jobs; to retain their jobs, others would have to relocate.

(c) Excluding the private sector from all or virtually all of the Ontario market may limit industry involvement in the remainder of the Canadian automobile insurance market and may create a shortfall in capacity in general insurance lines. (672-674)

F148. A public monopoly insurer will not achieve any efficiency gains attributable to economies of scale compared to major Ontario insurers. (677)

F149. Public monopoly automobile insurance has the potential to achieve cost savings when compared to a competitive automobile insurance industry in the private sector. The most important cost savings is lower business acquisition costs (mainly broker commissions); a less significant cost savings results from the probable use of a simplified classification system, or in the extreme as in Quebec and Saskatchewan, no classification system. These potential cost advantages depend not on the difference between public and private delivery, but on the difference between monopoly and competitive delivery. (683-684)

F150. The maximum potential cost savings that could be achieved by a public monopoly insurer is approximately 7% which translates into a premium reduction of about $43 per car. (687)

F151. If a simplified (or no) classification system is adopted, the impact of the aggregate cost savings will affect different insureds differently. The beneficiaries of the premium reduction will be Ontario's high risk drivers. Because of the change in the classification system, over 40% of Ontario's drivers who are now classified as low risk drivers will face premium increases on conversion to public automobile insurance. If a public monopoly insurer were to use a more complex classification system, potential cost savings would be reduced. (687-688)

F152. The start-up costs of a public automobile insurance corporation, the elimination of the benefits of competition and the likely increase in the number of high risk drivers (and therefore claims costs) will reduce, if not eliminate entirely, the potential for cost savings from conversion to public automobile insurance. (688-690)

F153. Freedom of choice and the benefits of competition are undeniable advantages of Ontario's private sector delivery system. (692)

F154. Cross-subsidization of high risk drivers by low risk drivers that is characteristic of the public plans is neither fair nor equitable. (692-693)

F155. The ability to integrate licensing and insurance requirements is an advantage of public automobile insurance. (697)

F156. The interest in and opportunities for the promotion of traffic safety are likely to be greater in a public than a private delivery system. Nevertheless, the government's interest in traffic safety and its commitment to accident prevention should not depend upon whether it is responsible for the automobile insurance system. (699)

F157. Automobile repair costs are lower in a private system than in a public system. (699-700)

F158. The fact that public plans pay no corporate income tax means that the loss of corporate tax revenues

will result in higher taxes in other areas. This is an indirect subsidy. (700)

F159. There is no justification for a policy on the part of a public insurer to invest within the province; over 70% of one public insurer's (I.C.B.C.) investments are out of the province. (700-701)

F160. There is no evidence to suggest that the consumers in the public plans are more or less satisfied than consumers in Ontario. This is particularly evident now that consumers in the public plans are faced with substantial premium increases. (701)

F161. Ontario taxpayers and drivers would not benefit from the conversion to public automobile insurance. The modest potential for cost savings particularly in the area of business acquisition costs would be offset in the short run by the substantial start-up costs of a public plan and would be completely eroded in the longer term by other cost-based considerations, particularly the elimination of the potential for lower premiums derived from competition. (708-709)

F162. There are no compelling social benefits or other non-economic justifications which support the case for public automobile insurance. An assessment of factors unrelated to cost efficiency reinforces the case against public monopoly. (709)

R134. The Government of Ontario should not introduce public automobile insurance. (709)

K. RATE REGULATION (Chapter 16)

F163. Some form of rate regulation, that is, some outside review of insurers' premiums is socially, if not economically, desirable. The public is entitled to some external protection against unreasonable or unjust premiums; at the same time, rate regulation should bring a measure of stability to the market. (720-721)

F164. The structure of the automobile insurance market in Ontario is consistent with a highly competitive industry. The large number of firms in the industry and their relative size distribution make collusion or cartel-like behaviour unlikely. (727)

F165. The conclusion that the automobile insurance industry in Ontario is competitive must be qualified in three respects:

(a) The broker and agent distribution system fragments the competitive market.

(b) In some particular markets (for example taxis), the competition is quite limited.

(c) The residual market, the Facility Association, is non-competitive. (727-728)

F166. The two dominant objectives of rate regulation should be premium fairness as assessed against sound insurance principles and market stability which will enure to the eventual benefit of the public. Appropriate rate regulation should provide a cost efficient mechanism for ensuring that premiums charged by individual insurers are fair and for ensuring market stability. (728-729)

F167. The proposed rate regulation legislation will inhibit insurers from being innovative in their rating procedures. (729)

F168. The public utility model of regulation, upon which the proposed rate regulation legislation is based, is inappropriate to a competitive industry even if the product is compulsory. (731)

F169. Industry-wide hearings will produce rates or ranges of rates that in many instances are higher than those that might be generated by competitive pricing with the result that the public will be denied the benefits of true competition. On a more specific level consumers will be denied the benefit of lower than benchmark rates which would be charged by the more efficient insurers in a truly competitive market. (731-732)

F170. The form of the process contemplated by the proposed rate regulation legislation will result in increased costs which will inevitably be passed on to consumers. The substance of the process will deny consumers access to the lower premiums generated by the more efficient insurers in a competitive market. (733)

F171. Without the provision of funding, public participation at industry-wide hearings cannot be meaningful. (734)

F172. The premiums in the Facility Association are lower than the expected loss costs of those who populate

the Facility Association suggest they should be, inevitably resulting in a measure of cross-subsidization. Thus, approval of Facility Association rates will involve substantial social policy considerations. (735-736)

R135. *The Government of Ontario should enact rate regulation legislation. The legislation should provide for the establishment of an independent board to review and approve the rates of individual insurers. (720-721)*

R136. *The Government of Ontario should not enact the proposed Ontario Automobile Insurance Board Act, 1987 in its present form. Specifically, the Board should not have the power to set rates. The Board's power should be limited to rate approval. (731-732)*

R137. *Whatever rate approval process is adopted, it should be one which will not unduly inhibit competition. (734)*

R138. *The Board should have the express power to approve deviated rates even where refinements to the classification system are involved, provided that the rates are otherwise just, reasonable and sound in principle. (729-730)*

R139. *Alternatively, the Board should have direct jurisdiction over the classification system and an unfettered power to modify it. (729-730)*

R140. To the extent the legislation permits public participation at Board hearings, the Government should make available reasonable funding in order to ensure that public participation is meaningful. (734)

R141. For clean risks the former Facility ceding arrangements should be put in place. This ceding should occur at an insurer's book premiums unless the insurer's premiums are below the range of rates set by the Board. (736-737)

R142. The Superintendent of Insurance should be permitted to participate in the Facility Association premium approval process, in order to ensure that the public interest is represented. (737-738)

L. MOTOR VEHICLE ACCIDENT PREVENTION (Chapter 17)

F172. Those killed in motor vehicle accidents tend to be young, healthy and male. Motor vehicle accidents are the leading cause of death for males between the ages of 15 and 24. (740)

F173. In 1985 dollars, economic loss resulting from Ontario motor vehicle accidents is approximately $1.7 billion. (742)

F174. The reduction in speed limits has worked to reduce accident frequency and severity; mandatory seat belt legislation has worked to reduce accident severity. (760-761)

R143. Responsibility for traffic safety should be reposed in one government department or independent agency. (752-753)

R144. Speed variation increases the risk of accidents and should be controlled. Both minimum and maximum speed limits should be enforced. (760)

R145. Parents charged with failing to use child restraints in motor vehicles should be given the choice of paying the fine or establishing to the court that a child restraint has been purchased, rented or borrowed. (762)

R146. The legal age for drinking and the legal age for driving should be given further study. (767)

R147. Driver education should be taught at a much younger age than 15; it should be taught as part of a course in acceptable social behaviour and not as part of a crash course leading to the acquisition of a driver's licence. (767)

CHAPTER 2

INTRODUCTION

This Inquiry is the fourth major study in Ontario within the past 15 years in which the compensation of those injured in motor vehicle accidents has been considered. The earlier studies to which I refer are the 1973 Ontario Law Reform Commission Report on Motor Vehicle Accident Compensation; the 1977, 1978 and 1979 Reports of the Select Committee on Company Law in which automobile insurance and compensation-related issues were considered, and the 1986 Ontario Task Force on Insurance, which considered problems in the property/casualty insurance industry in Ontario in response to what has become known as "the liability insurance crisis" of 1985-86.

Although the Ontario Task Force on Insurance regarded problems in automobile insurance as being separate from the root causes of the liability insurance crisis, the Task Force recommended a pure no fault compensation scheme for those injured in motor vehicle accidents. As the Task Force clearly ow d its existence to the liability insurance crisis and, as this Inquiry owes its existence to the recommendation of no fault automobile insurance by the Ontario Task Force on Insurance, I think it can be said that the liability insurance crisis of 1985-86, at least indirectly, led to this Inquiry.

I will return to the report of the Ontario Task Force on Insurance after briefly considering the 1973 Report of the Ontario Law Reform Commission and the 1977, 1978 and 1979 Reports of the Select Committee on Company Law.

A. THE ONTARIO LAW REFORM COMMISSION 1973 REPORT

The Ontario Law Reform Commission's (O.L.R.C.) examination of automobile accident compensation and the tort system extended over a six year period. In its 1973 Report, the O.L.R.C. recommended replacing the tort system with a no fault system of compensation.[1]

The O.L.R.C. was impressed by the rationality of New Zealand's comprehensive accident compensation scheme. Uncompensated automobile accident victims, delay, cost and uncertainty, particularly in the determination of fault, were all matters which led the O.L.R.C. to the conclusion that tort had outlived its usefulness as a system of motor vehicle accident compensation. The Commission's 1973 Report emphasized the excessive consumption of court time by motor vehicle accident cases (said by the O.L.R.C. to be 40%)[2] and the undermining of the traditional notion of fault by liability insurance. The O.L.R.C. concluded that the tort system had no meaningful capacity for deterrence.[3] In dealing with the deterrence issue, the Commission referred to, and accepted, this statement from a Report of the New York State Insurance Department:

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[1] Ontario Law Reform Commission, Report on Motor Vehicle Accident Compensation (Toronto: The Commission, 1973). [Henceforth: O.L.R.C., Report (1973)].

[2] O.L.R.C., Report (1973), p. 15.

[3] O.L.R.C., Report (1973), p. 18.

> Individual, last moment driver mistakes--undeterred by fear of death, injury, imprisonment, fine or loss of licence--surely cannot be deterred by fear of civil liability against which one is insured. Indeed, as a matter of logic, the contrary is true.[4]

This statement was also referred to in the 1986 Ontario Task Force on Insurance Report[5] about which more will be said shortly.

In dealing with the no fault benefits in the Ontario standard form of automobile insurance policy, the O.L.R.C. rejected the concept of an "add on system" in which no fault benefits are available in addition to tort rights and credit is given in the third party action for no fault benefits paid or available. The O.L.R.C. also concluded that losses occasioned by motoring should be internalized and that double recovery should be eliminated.[6] The O.L.R.C.'s view was that no fault benefits should be "primary".[7] This issue involves consideration of both

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[4] New York State Insurance Department, Automobile Insurance. . . For Whose Benefit?, A Report to Governor Nelson A. Rockefeller (New York: The Department, 1970), p. 12.

[5] Ontario Task Force on Insurance, Final Report (Toronto: Ministry of Financial Institutions, 1986). [Henceforth, Ontario Task Force on Insurance, Final Report (1986)].

[6] The Commission recognized that this change would have to be made by legislation because of the Ontario Court of Appeal decision in Boarelli v. Flannigan, [1973] 3 O.R. 69 (C.A.).

[7] Primary benefits are those paid regardless of other benefits to which the insured may be entitled. Primary benefits may be contracted to non-primary or secondary benefits which are paid only after other benefits to which the insured may be entitled have been taken into account. Ontario's existing no fault benefits contained in Section B of the automobile policy are not primary.

cost and fundamental policy objectives. It is clear that the conclusion that no fault benefits should be primary was based on policy grounds as the O.L.R.C. did not calculate the cost of this or other recommendations.

Although the O.L.R.C. advocated a pure no fault automobile accident compensation scheme, the recommendation was conceptually encumbered by the Commission's view that the no fault system should be a "first step" to the adoption of a comprehensive accident compensation scheme; the O.L.R.C. envisaged this as similar to the proposed New Zealand system, a universal publicly-run accident compensation scheme adopted in 1974.

The O.L.R.C. Report was criticized for recommending "sweeping changes" without reasonable consultation, and for relying on stale and inapplicable statistics. The O.L.R.C. was also accused of having failed to commission research of its own. It relied on earlier studies done in Michigan, Washington, England, British Columbia and Ontario. The Ontario study was done by Osgoode Hall Law School in 1961. Its author, Professor Allen Linden (now Mr. Justice Linden and President of the Law Reform Commission of Canada), in a subsequent paper, criticized the O.L.R.C. Report, stating that "...data collected in 1961 should not be relied upon to evaluate the auto insurance system of 1975."[8]

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[8]Allen M. Linden, "Faulty No-Fault: A Critique of the Ontario Law Reform Commission Report on Motor Vehicle Accident Compensation," Osgoode Hall L. J. 13, no. 2 (1975): 452.

Mr. Justice Linden emphasized that the O.L.R.C.'s proposal for a sweeping change to pure no fault was not costed; the Commission did not consider what the impact of its suggested changes on automobile insurance premiums would be. He was also critical of the O.L.R.C.'s assessment of the objectives of the tort system. He conceded that if the only purpose of the tort system was to provide compensation, as emphasized by the O.L.R.C., it could be justifiably discarded. It was, and is, Mr. Justice Linden's view that the tort system plays a role far beyond compensation. Another criticism of the O.L.R.C. Report was based on the premise that although data collected in 1961 could be relevant to the circumstances of the mid-1970s, there were a number of intervening changes in Ontario motor vehicle insurance and compensation law which made that data less significant in its weight. These changes included the institution of compulsory no fault benefits in 1972, the evolution of Ontario automobile accident-related negligence law and social welfare legislation.

B. THE SELECT COMMITTEE ON COMPANY LAW REPORTS, 1977, 1978 AND 1979

The O.L.R.C. Report stimulated interest in no fault compensation schemes, but did not elicit a legislative response to its no fault proposal. On May 25, 1976, the Select Committee on Company Law (a committee of the Ontario Legislature) was reconstituted to inquire into "...the business of insurance companies ...". The Committee's mandate included an obligation to review all aspects of automobile insurance. The Committee's Reports are thorough and comprehensive and many of its recommendations became part of Ontario's automobile insurance compensation law. I do not propose to review

the details of all of the Committee's recommendations, given my intention to refer to these more recent automobile accident compensation studies for background purposes only.

The Committee's first Report was submitted in 1977.[9] Among many other things, it recommended an increase in the existing no fault benefits, which by 1972 were part of Ontario's compulsory automobile insurance package. The recommendation was to increase the maximum weekly disability benefit (earnings replacement) from $70 to $140. The Legislature accepted this recommendation in 1978. Disability benefits have not increased since that time. Other no fault benefits (death, funeral, replacement services) were also increased in response to the Committee's recommendations.

The Committee's 1977 Report dealt with no fault automobile accident compensation in a chapter entitled: "Topics for Subsequent Consideration".[10] The Committee resolved to consider further a no fault compensation scheme, having in mind "the problems" in the areas of bodily injury and property compensation, and the issues of no fault's impact on premiums, reparations, the courts and other parts of the automobile insurance system. This further consideration was made by a reconstituted

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[9]Ontario. Legislative Assembly. Select Committee on Company Law, The Insurance Industry: First Report on Automobile Insurance (Toronto: Legislative Assembly, 1977). [Henceforth: Select Committee on Company Law, First Report (1977)].

[10]Select Committee on Company Law, First Report (1977), p. 241.

Committee whose 1978 Report[11] contained recommendations on compensation for those suffering injury and loss as a result of automobile accidents.

The Committee heard 80 witnesses, including 40 in out of province sessions. The Committee's investigation into no fault included a consideration of "Variplan" (the insurance industry's no fault proposal of the 1970s). In its 1978 Report, the Committee recommended a threshold no fault system for compensating those injured in automobile accidents. The Committee dealt with the issue of premiums in its proposed no fault regime with obvious caution. The Committee concluded that the "...introduction of no fault compensation is unlikely to effect a reduction in total automobile insurance costs..." but that no fault could compensate "...the average injured person for substantially the full extent of his economic losses without effecting any significant increase in total automobile insurance costs".[12] It is apparent that certainty, promptness and efficiency were prominent objectives of the Committee's no fault recommendations.

Although the Committee was impressed with the concept of a pure no fault system,[13] it seems to have been

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[11]Ontario. Legislative Assembly. Select Committee on Company Law, The Insurance Industry: Second Report on Automobile Insurance (Toronto: Legislative Assembly, 1978).

[12]Select Committee on Company Law, Second Report (1978), p. 162.

[13]For purposes of simplistic analysis, pure no fault can be regarded as a compensation system in which the third party right to sue based on fault is eliminated completely. In pure no fault, all benefits are paid but

concerned about "...an expectation among the insured public of compensation for categories of loss such as pain and suffering ...".[14] The Committee responded by recommending that there be a no fault provision for non-economic loss (to be paid by the first party insurer);[15] the quantum of that non-economic loss was to be scheduled to "...provide an exact amount for each type of injury."[16]

The Committee concluded that more seriously injured plaintiffs should have access to the courts for the assessment of non-economic loss on an individual, non-scheduled, case by case basis. The Committee recommended a verbal threshold to define those more serious cases which would have access to the courts. The threshold recommended is set out at page 167 of the Committee's Report as follows:

> (a) He must be able to establish that he has suffered:
>
> (i) serious and permanent injury resulting in substantial and medically demonstrable impairment affecting the resumption of customary activities; or
>
> (ii) permanent loss of important bodily functions; or

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on a first party no fault basis. Quebec has the only pure no fault plan for bodily injury in North America.

[14] Select Committee on Company Law, Second Report (1978), p. 166.

[15] The Committee split 8 for, 6 against (no abstentions) in favour of its no fault recommendation.

[16] Select Committee on Company Law, Second Report (1978), p. 166

(iii) significant permanent scarring or disfigurement;

otherwise he is not to be entitled to make a claim whatever against any third party.

(b) He must be able to establish at the very beginning of any litigation that the gravity of his injuries fulfills one of the foregoing tests, otherwise he is not to be entitled to continue the prosecution of his claim.

(c) His right of recovery should be subject to the traditional rules of the law of negligence, so that the customary inhibitions of the fault system will apply.

(d) The compensation which he may recover should be limited to non-economic losses for which no compensation is provided under the no fault program.

(e) There should be a limit on the amount recoverable under this provision. The Committee considers that $100,000 is a reasonable maximum.

It is clear that it was the Committee's intention to deal with the vast majority of cases for non-economic loss on a scheduled basis with '"extra-ordinary" claims', that is, claims passing the threshold, being dealt with in the tort system.[17]

In the end result, for bodily injury claims, the Committee recommended unlimited medical and hospital rehabilitation benefits, payment of economic loss on a no fault basis, unlimited as to time but subject to a weekly

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[17]Select Committee on Company Law, Second Report (1978), p. 167.

maximum, and payment of non-economic compensation for all except the most serious injuries on a scheduled basis. The Committee recommended that access to the courts be preserved for cases passing a verbal threshold, subject to a maximum non-pecuniary damage assessment potential of $100,000.

The Committee also recommended that vehicle damage be dealt with on a no fault basis. Its approach to collision insurance was somewhat different from that taken in the 1973 O.L.R.C. Report. The Committee recommended that every automobile policy should contain, as a compulsory feature, a form of coverage under which the insurer agreed to pay its insured's collision damage up to $250, to the extent that the insured was able to establish his innocence. It was contemplated that this would be done by way of a fault chart, although the Committee did not emphasize this to any significant degree. Beyond the mandatory first party fault-based access to the first $250 loss, vehicle owners would be able to purchase collision coverage on an optional basis. The Committee obviously contemplated a collision coverage plan, similar to the vehicle damage part of Michigan's threshold no fault scheme. The net result of the recommendation was that if an insured did not buy any collision coverage, his insurer would be obliged to pay nothing above the mandatory first party coverage.

The Committee emphasized that its collision damage recommendation was based on a premise that all collision damage compensation would be paid on a first party basis. There would be no right of action against any third party wrongdoer, either by the insured suffering the collision damage, or by his insurer through subrogation.

Although cost, and a desire to compensate all victims of automobile accidents, were paramount considerations, the Committee seems to have been responsive to a concern about public expectations, particularly in the area of non-pecuniary relief. It was this concern that seems to have caused it to recommend fault charted, non-pecuniary relief for cases falling below the recommended threshold and access to the courts for cases meeting the threshold.

The Committee recommended that the threshold issue be determined at the time proceedings are commenced.[18] This seems to me to be impractical. It would necessarily lead to delay, especially in those grey area cases where there is some real question as to whether the injured person met or did not meet the threshold. Substantial transaction costs would be added to the system if the threshold issue were decided in a proceeding separate from the trial. The determination of the threshold issue at the time of the commencement of the proceedings is a practice which has not been adopted in those jurisdictions in the United States having either monetary or verbal thresholds.

The Committee's treatment of the deterrence issue, as related to both the tort system and its recommended substitution, no fault, was somewhat superficial. The Committee considered the prospect of one's own death or injury, the criminal law, the anguish of being involved in an accident, and licence suspension as being the major

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[18] Select Committee on Company Law, Second Report (1978), p. 167, para. 6(b).

deterrence-related factors. No specific consideration seems to have been given to the impact of no fault, in and of itself, on the deterrence issue.

C. THE ONTARIO TASK FORCE ON INSURANCE 1986 REPORT

From 1978 through 1986, the debate over no fault compensation for automobile accident victims was ubiquitously muted. Some (particularly academics repelled by the tort system's failure as a compensation system) continued the no fault debate. New Zealand's comprehensive, but still unexported, accident compensation scheme and some of the threshold no fault plans in the United States were looked to as models. Then came the liability insurance crisis of 1985-86.

In late 1985 and through most of 1986, certain liability risks became uninsurable and other risks were insurable only with dramatically increased premiums. Policy limits were lowered, deductibles were increased, exclusions were expanded and policy forms were changed to claims-made as opposed to occurrence-based. Manufacturers, exporters to the United States, day care centres, truckers, bus and transit operators, municipalities and school boards, professionals, directors and officers, sport and recreation groups, hospitals and the hospitality and tourism industry were all identified within Ontario as being victimized by the liability insurance crisis.[19]

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[19] Ontario Task Force on Insurance, Final Report (1986), pp. 32-34.

Collusion among insurers, cash flow underwriting responsive to high interest rates, and the cyclical nature of the insurance industry, resulting in an inevitable inverse relationship between investment income and premiums, were three of the prominent explanations for the crisis.[20] The United States Justice Department rejected all of these and concluded that the expansion of corporate liability exposure in tort law had led to the crisis.[21] In Ontario, Professor Michael Trebilcock reached much the same conclusion.[22]

Liability insurance through this period was either unavailable or too expensive for many. Affordability, availability and fairness were dominating liability insurance issues which eventually triggered a political response. That political response was the appointment of a Task Force on January 9, 1986 by the Minister of Consumer and Commercial Relations. The Task Force's mandate was to find "solutions for cost and capacity problems in the property and casualty insurance industry in Ontario". The Task Force's recommendation of no fault automobile insurance led to this Inquiry.

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[20]George Priest, Modern Tort Law and the Current Insurability Crisis (Working Paper No. 44 of the Program in Civil Liability, Yale Law School, February 1987); David Gill, Liability Insurance: Crisis in Supply (Vancouver, B.C.: The Fraser Institute, 1987).

[21]U.S. Department of Justice. Tort Policy Working Group, Report on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability (Washington: U.S.D.J., 1986); An Update to the Liability Crisis (Washington: U.S.D.J., 1987). [Henceforth: Tort Policy Working Group, Report (1986)].

[22]Michael J. Trebilcock, The Insurance-Deterrence Dilemma of Modern Tort Law (University of Toronto, May 1986).

By any reasonable standards, the Task Force Report represents an impressive undertaking. It provides a comprehensive analysis of the liability insurance crisis and proposes a number of sensible, and, I think, workable recommendations.

The Task Force concluded that the liability insurance crisis could be resolved neither by tort reform nor by the resolution of issues which later collectively became known as the "justice issues".[23] The Task Force concluded that changes in joint and several liability, the collateral source rule, gross-up (structured settlements), damage assessment excesses resulting from the Family Law Reform Act (F.L.R.A.) (now Family Law Act, 1986 (F.L.A.))[24] and prejudgment interest would not solve the liability insurance crisis. The crux of the Task Force's conclusion was that the tort system itself was the root cause of the problem. This statement appears at page 58 of the Task Force Report:

> The Task Force has concluded, however, that the problems that pervade the personal injury area and that in large measure have caused the current liability insurance "crisis" cannot be resolved through further reform of the tort system.

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[23]The "justice issues" include prejudgment interest, Family Law Act claims, gross-up (structured settlements), joint and several liability and the collateral source rule.

[24]R.S.O. 1980, c. 152; S.O. 1986, c. 4.

The Report deals with automobile insurance under the heading of "Other Insurance Issues".[25] This designation of the subject was appropriate as automobile insurance fell outside the ambit of those matters directly relevant to the liability insurance crisis. The separation of automobile insurance problems from liability insurance issues is first specifically recognized at page 23 of the Report:

> ...although there is no general crisis of price or availability of personal automobile insurance in Ontario, there are clear indications of a trend of increase in the real cost of claims for bodily injury, together with indications of a trend towards a more litigious approach to such claims. These trends have little to do with the insurance cycle, but they have become more visible as the trough of the shift to a hard market has approached.

The Task Force envisaged a "no-tort" (the Task Force purposefully distinguished no-tort from no fault) first party comprehensive accident compensation scheme, run by the private sector.[26] Quebec's no fault automobile accident compensation plan and New Zealand's comprehensive accident plan (each delivered by a public monopoly) were relied on as precedents, if not models. The Task Force recommended that in its first stages, the no fault accident compensation scheme should apply only to automobile accident injury compensation.

To understand the Task Force's recommendations on automobile insurance, it is important that they be placed

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[25] Ontario Task Force on Insurance, Final Report (1986), p. 71.

[26] Ontario Task Force on Insurance, Final Report (1986), p. 67.

in the appropriate context. The Task Force Report's long-term recommendation was for a comprehensive, no fault disability compensation scheme. The recommendation for no fault automobile insurance and automobile accident compensation seems to have been subservient to the recommendation that accident compensation generally be on a no fault, first party basis.

In dealing with the issue of automobile insurance and automobile accident compensation, the Task Force recommended a first party no fault plan with disability benefits of approximately $600 a week maximum. The idea was to provide income replacement in response to automobile accident-caused disabilities for a "...clear majority of the population of Ontario ...".[27] The Task Force made recommendations for the provision of disability benefits to students, homemakers and children as well as unlimited medical and rehabilitation benefits.

Although pure no fault (a no fault plan providing no access to third party fault-based relief) was the Task Force's clear preference, the Report made an alternative recommendation of threshold no fault. The preferred threshold was not described, although the Task Force seemed to have been impressed with the Michigan threshold no fault compensation scheme. Michigan's threshold, aside from death and a cosmetic injury provision, requires a "serious impairment of body function" before an injured person can sue on a fault basis for non-economic loss (pain, suffering, loss of enjoyment of life).

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[27] See Ontario Task Force on Insurance, Final Report (1986), p. 77.

In dealing with premium rating, the Task Force recommended a bonus/malus rating system.[28] It is not entirely clear to me whether this was to be the basis of premium rating, or simply a premium surcharge mechanism, to operate along with a remodelled classification system with the eventual elimination of age, sex and marital status as rating criteria.

Although the Task Force Report was generally applauded, its "first step", no fault automobile insurance, elicited considerable criticism. The absence of costing, the approach to the deterrence issue, the failure to consider the prospect of improving Ontario's present add-on system and the Task Force's criticism of the tort system for not being able to do what it was allegedly never intended to do, were some of the more prominent issues raised in the critical response to the Task Force Report.

As the liability insurance crisis diminished toward the latter part of 1986, automobile insurance increasingly became a social and political problem. Premium levels, the abuse of the residual market, unacceptable underwriting practices, and the industry's failure to deliver first party no fault benefits promptly were the most commonly voiced complaints. The decibel level of cries for a government takeover of automobile insurance increased. On April 23, 1987, the provincial government undertook a number of initiatives. Premiums were frozen

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[28] Ontario Task Force on Insurance, Final Report (1986), p. 82.

at April 23, 1987 levels and premium roll backs were mandated for taxis and males under 25. This was clearly a political response to what was thought to be a political problem.

On April 23, 1987, the Minister of Financial Institutions also announced that automobile insurance would henceforth be subject to regulatory control and draft legislation was quickly prepared. This legislation will be discussed in more detail in Chapter 16 dealing with rate regulation. For now all that need be said is that the proposed regulatory scheme would have an independent rate review board establish relevant rates, or a range of rates, within a mandated classification system. This would be achieved through industry-wide hearings open to the public. Once rates or ranges of rates were established, insurers would file their proposed rates for approval.

The Legislature rose for its summer recess before the Minister's April 23rd proposals had been dealt with. Nevertheless, most insurers gave refunds to policyholders who would have been entitled to a premium reduction, thus giving effect to the Minister's intent to freeze premiums as of April 23, 1987.

It is against this background that this Inquiry proceeded. I have attempted to approach all relevant issues fairly and in an atmosphere of full consultation. I have listened to and received written submissions from the public, interested groups and organizations and from those pejoratively described as "special interest groups". All have been helpful. In the final analysis, I confess

to having considered the interests of those who purchase automobile insurance and those who are injured in motor vehicle accidents as the dominant interests to take into account.

CHAPTER 3

WORK OF THE INQUIRY

A. ADVISORY COMMITTEE

The Order-in-Council authorizing this Inquiry directed me to establish an Advisory Committee whose members were to be appointed in consultation with the Attorney General and the Minister of Financial Institutions. The Committee members were drawn from three groups affected by the outcome of the Inquiry: the insurance industry, the Bar and the public. The Superintendent of Insurance, John P. Weir, was made an ex officio member of the Advisory Committee. I am grateful to him for his assistance both at the Advisory Committee level and throughout.

Counsel and I met with the Committee on a monthly basis from February to October, 1987, to discuss major issues, submissions and research projects. The Committee members each made a significant contribution to the work of the Inquiry. Their views on relevant issues were expressed with clarity, reasonable persistence and in an atmosphere of civility.

B. WRITTEN SUBMISSIONS

The Inquiry placed advertisements in newspapers and journals throughout Ontario inviting submissions. All those who made submissions or responded in writing to recommendations of the Ontario Task Force on Insurance were advised that their submission to the Task Force, or their response to the Task Force's Report would be considered along with submissions made directly to this

Inquiry. I reviewed over 200 submissions to the Task Force on Insurance and over 140 to the Inquiry.

I have received written submissions from the insurance industry, the Bar, the automotive industry, health care professionals, academics, government departments, the New Democratic Party, consumers, victims of automobile accidents and from consumers having particular concerns or complaints about automobile insurance-related matters.

C. PUBLIC HEARINGS

Informal hearings were held in Toronto, Ottawa, Thunder Bay, Kitchener, London and Windsor. These hearings were advertised in appropriate newspapers and attended by interested members of the public and those who had made written submissions. In many respects the evidence received at these informal hearings mirrored the written submissions made to the Inquiry. Consumers having automobile insurance-related concerns, motor vehicle accident victims, health professionals (including rehabilitation specialists), the insurance industry (adjusters, brokers and companies), the Bar and some interested in Inquiry issues from a political perspective gave evidence or made statements at these hearings. I am grateful to all those who took the time to attend these hearings.

D. MEETINGS AND TRAVEL

I thought it sensible to seek advice and information from outside Ontario. Accordingly, counsel and I travelled to other provinces, Europe and the United States.

Where possible, I attempted to obtain a balance of opinion. Counsel and I met with insurers, lawyers, judges, government insurance officials, consumer advocates, rehabilitation specialists, doctors, academics, court officials and consumers. Throughout, I received an abundance of hospitality, cooperation and assistance.

We visited Manitoba, Saskatchewan, British Columbia and Quebec because those provinces have government-delivered automobile insurance plans. I am grateful to all those who assisted counsel and me to better understand the structure and performance of those government insurance plans. My gratitude extends to officials of the Quebec Régie, the Manitoba Public Insurance Corporation, the Saskatchewan Government Insurance office and the Insurance Corporation of British Columbia. I also appreciate the assistance provided by judges, lawyers, academics, consumers and politicians in those provinces.

Edmonton, Alberta, was more than a pitstop between Saskatchewan and British Columbia. My gratitude is extended to the chairman, counsel and staff of the Alberta Automobile Insurance Board, as well as those in the academic community and judges, who were kind enough to meet with us.

Travel to the United States was directed to those states having threshold no fault plans. We travelled to Michigan (on three occasions), Minnesota, New York, Pennsylvania and Florida. In each state we met with government insurance officials, attorneys and, in some instances, judges.

We also travelled to Washington, D.C. to meet with officials of the Department of Justice, the U.S. Department of Transportation, the General Accounting Office and the National Insurance Consumers' Organization.

At the invitation of the Minister of Financial Institutions and the Superintendent of Insurance, counsel and I also travelled to England, Germany, Switzerland and France to speak with executives of major insurance companies doing business in Ontario and to obtain information about compensation schemes in Europe. We were particularly interested in the Swiss bonus/malus rating system which the Ontario Task Force on Insurance recommended incorporating into Ontario's system of premium rating. Our visit to France was short. We spoke to Dr. Andre Tunc, author of numerous books and articles on no fault insurance. In England, we met with insurers, politicians, the Bar and academics.

E. RESEARCH REVIEW

In May 1987 we met with a number of distinguished academics to discuss major insurance compensation issues. The participants at this meeting, chaired and organized by Professor Michael Trebilcock of the University of Toronto, included: J. Robert S. Prichard, Dean, Faculty of Law, University of Toronto; Professor Paul Halpern, Faculty of Management Studies, University of Toronto; Professor Samuel A. Rea, Jr., Institute of Policy Analysis, University of Toronto; Professor Peter Hogg, Osgoode Hall Law School, York University; Professor Marc Gaudry of the Université de Montréal; Professor Gary Schwartz of the University of Southern California; Professor Stephen Sugarman of the University of California at Berkeley; Dr.

Patricia Danzon, Associate Professor, Health Care Systems and Insurance, The Wharton School, University of Pennsylvania; and Professor Jeffrey O'Connell of the School of Law, University of Virginia.

In a one and one-half day session, we evaluated the current system of motor vehicle accident compensation in Ontario. We examined the basic alternatives: retention of the tort system with an expansion of no fault benefits, threshold no fault (monetary or verbal), pure no fault and other available alternatives. Finally, we dealt with the issue of a privately-run versus publicly-run automobile insurance system.

F. RESEARCH STUDIES

The research studies commissioned for the Inquiry focussed on certain basic questions about the current system of motor vehicle accident compensation and the effect of proposed changes to the system.

Joe Cheng, an actuary with Eckler Partners Ltd., and an invaluable consultant to the Inquiry, conducted three claims surveys and provided endless helpful advice. The first claims survey covered bodily injury liability claims closed during 1986; the second survey covered accident benefits claims for accidents which occurred in 1985; the third survey dealt with ongoing bodily injury liability claims which were closed during a six-week period in 1987. These surveys will be referred to in detail later. In general, the idea was to examine and break down both liability insurance and accident benefit payments to identify the components of claims paid, the economic and

injury profiles of claimants, transaction costs and collateral sources of compensation.

The data from the surveys were also used to determine what increases or decreases in costs would result from the implementation of a variety of compensation plans under consideration.

Professor Samuel Rea, Jr., constructed a model which allowed him to combine a number of unrelated data sources into a single sample which simulated the population of motor vehicle accident victims. The purpose of the study was to pinpoint gaps in coverage and estimate the effects of changes in insurance coverage and benefit levels.

Reginald Spear, Director, Insurance Industry Consulting Services of Peat, Marwick and Partners conducted a series of interviews with insurance company executives to present a profile of the automobile insurance business -- its pricing, sales and marketing, claims settlement, policy administration and accounting methods.

Professor Paul Halpern, together with a research team, analysed the structure of Ontario's automobile insurance industry from the point of view of industrial organization. He then compared the relative efficiency of Ontario's system of compensation with the publicly-run automobile insurance schemes in British Columbia, Manitoba and Saskatchewan. This study was directed to the role government should have in the regulation and delivery of automobile insurance.

The Inquiry also commissioned a research study from Professor Gerald Wilde of Queen's University on the issue of road safety, particularly through incentives and deterrence.

Dr. Norman White of the Faculty of Health Sciences at McMaster University provided a paper on the function of deterrence in motor vehicle accident compensation schemes.

Professor Marc Gaudry prepared a paper based upon his extensive research following the introduction of no fault in the province of Quebec and dealing with the issues of deterrence and an optimal approach to premium rating in a no fault environment.

Professor Peter Hogg provided an opinion to the Inquiry on the constitutionality of pure and threshold no fault plans and related issues.

I also wish to acknowledge the assistance provided by many of the research papers prepared for the Ontario Task Force on Insurance. Many of those research papers were helpful to me in examining issues before this Inquiry.

CHAPTER 4

THE AUTOMOBILE INSURANCE INDUSTRY IN ONTARIO

A. STRUCTURE

Ontario's 5.7 million drivers buy compulsory and optional insurance from 102 insurers, including individual companies and corporate groups.[1] These companies include:

(i) Ontario chartered companies;
(ii) federally chartered Canadian companies;
(iii) extraprovincial chartered companies; and
(iv) federally registered branches of British and foreign insurance companies.

The direct premium income generated by the sale of automobile insurance in Ontario amounts to approximately $3 billion annually. All insurance companies selling automobile insurance in Ontario must be licensed.

Based on premium income, the top 10 insurers in Ontario have 53% of the market. The top 20 insurers have 74% of the market. Fifty-two insurers write more than

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[1]To identify the number of insurers selling automobile insurance in Ontario, insurers have been counted on a group basis. For example, the Economical Group includes Economical Mutual Insurance Company, Perth Insurance Company and Missisquoi and Rouville Insurance Company. The Halpern study, Inquiry Research Study II, indicated that, as of 1984, there were 112 groups of insurers writing automobile insurance in Ontario. Sixty-six of those groups accounted for over 99% of the business.

$10 million of automobile insurance premiums annually.[2] The market is unconcentrated. The concentration ratios for the top four (C4), top eight (C8) and top 20 (C20) insurers from 1974 through 1984 can be seen from Table 4.1 below. Appendix XVIII sets out the 52 companies writing more than $10 million of automobile insurance premiums in 1986.

TABLE 4.1

CONCENTRATION RATIOS FOR ONTARIO

AUTOMOBILE INSURANCE[3]

	C4	C8	C20
1974	27.43	42.59	66.59
1975	28.90	44.28	67.62
1976	30.46	47.86	71.88
1977	33.90	51.21	75.17
1978	36.66	54.21	79.81
1979	36.89	55.79	83.48
1980	33.32	51.39	77.89
1981	31.10	48.34	75.32
1982	27.57	44.51	71.80
1983	27.94	44.84	73.95
1984	27.82	44.53	73.95

The Compulsory Automobile Insurance Act makes it unlawful for an owner of a motor vehicle to operate that motor vehicle on a highway, or permit that vehicle to be operated on a highway, unless the vehicle is insured.[4] Bodily injury and property damage coverage, to minimum

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[2] Canadian Insurance Agent and Broker, 1987 Annual Review of Statistics.

[3] Superintendent of Insurance for Ontario, Annual Reports, for years 1974 to 1984. Industry concentration ratios will be dealt with in Chapter 16.

[4] R.S.O. 1980, c. 83, s. 2.

limits of $200,000, is compulsory. Accident benefits (no fault) coverage[5] is mandatory as is uninsured/unidentified motorist coverage.[6] The Compulsory Automobile Insurance Act has created a legislated coverage demand, but the Insurance Bureau of Canada estimates that more than 90% of motor vehicle owners were insured before insurance became compulsory in 1980. Police accident records indicate that approximately 98% of motor vehicle owners in Ontario are insured.[7]

The automobile insurance market may be divided into four areas: the standard market, the substandard market, the residual market and the specialty market (taxis, long-distance haulers, motorcycles and other identified singular risk groups).[8] The standard market is a somewhat amorphous term; its definition depends upon the willingness of the insurance companies to provide coverage at any given time. In general, the standard market

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[5] R.S.O. 1980, c. 218, ss. 232, 233.

[6] Insurance Act, R.S.O. 1980, c. 218, ss. 219, 231.

[7] It is interesting to compare the Ontario situation with that of Florida. Florida is a populous state where bodily injury and property damage coverage is not compulsory. Limited no fault coverage ("personal injury protection" coverage) is mandatory. In a meeting with Florida state government insurance officials, I was told that 31% of motor vehicles in the state were not insured for third party bodily injury and property damage; in Dade and Broward counties (counties including the cities of Miami, Fort Lauderdale and Pompano Beach), 55% of motor vehicle owners have no third party bodily injury and property damage coverage. Many of those who have the optional coverage carry only Florida's minimum limits -- $10,000 for an injured person and $20,000 for each accident.

[8] The specialty market seems to be vanishing. There are individual insurers who appear prepared to accept specialty risks.

includes people whom insurers consider to be among the better risks in the population. Not all those who are insured through the standard market are free of at-fault accidents or driving-related convictions. Standard market risks may be rated as preferred risks; some insurers have an even higher classification. Many companies employ a "star" system for characterizing insureds. In the standard market, six stars is the highest internal classification and zero is the lowest. An increasing number of insurers attempt to identify the best standard market risks; this risk group is given a preferred risk designation with an accompanying premium reduction.

If an insured's driving record, or some other factor, results in an application for insurance being declined, the applicant may seek insurance from other companies in the standard market or through what has been characterized as the substandard market. In Ontario, there are three companies whose marketing policy is directed toward the substandard market; these companies seek and write good surchargeable business.[9] For example, the substandard market will often insure a driver who has been convicted of impaired driving; the underwriting theory is that the conviction may not indicate more than transitory aberrant driving behaviour. Two of the three companies in the substandard market will not insure newly licensed drivers, at least until those drivers have acquired one year's driving experience. If nothing else, this shows the substandard market's response to both age and driving

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[9]These companies are: Pafco, Progressive Casualty and Kingsway General Insurance.

experience as underwriting factors. In hard market times, business in the substandard market expands.

The substandard market's premium rates are related to those charged by the residual market, the Facility Association. Substandard premium rates are generally 7.5 to 10% below residual market rates. An insured unable to obtain coverage in the standard market has two real choices. One is to attempt to obtain coverage through the substandard market at Facility Association rates, less 7.5 to 10%; the other is to insure through the residual market. If the consumer is aware of the existence of the few substandard market writers, the choice is clear.

The residual market is for those who cannot obtain insurance in the standard and substandard markets. It was created 33 years before automobile insurance was made compulsory. In 1947, Ontario insurers, with the concurrence of the provincial government, established the Ontario Assigned Risk Plan to provide coverage for high risk drivers. Applicants who had been refused coverage by at least two insurers were assigned to licensed insurers on a prorated basis.

In 1967, a new residual market, The Facility, was created by the insurance industry to replace the Assigned Risk Plan and to operate on a Canada-wide basis. Unlike its predecessor, the Assigned Risk Plan, The Facility was a risk-pooling mechanism. Each province's residual market activity and results were separately maintained. An insurer could cede 85% of a risk to The Facility if it considered that its book premium was inadequate. The insurer retained 15% of the risk. In The Facility environment, insurers accepted risks through the corporate

front door and ceded them through the back door. One of the objectives was to remove the stigma from insureds who had been placed in the Assigned Risk Plan after being refused insurance through the standard market.

On December 1, 1979, The Facility was replaced by the Facility Association, Ontario's current residual market. The change came about because of two major complaints from a number of Ontario insurers. They were:

1. Each company had its own rates and surcharges so it was thought that companies ceded business to The Facility at inappropriately low rates (given the nature of the risk being ceded).

2. Some insurers suspected others were ignoring underwriting criteria and charging premiums at inappropriately low rates on the ceded business considering the risk being written.

Third party liability and accident benefits coverage became compulsory in 1980. Compulsory insurance and the fact that insurers were not required to take all comers made it imperative that insurance would be available to all those required by law to purchase it. This was accomplished by bringing the residual market, the Facility Association, within the perimeters of the Compulsory Automobile Insurance Act.[10]

Consumer contact with the Facility Association is available through 11 servicing carriers:

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[10]R.S.O. 1980, c. 83, s. 7.

Allstate Insurance Company of Canada
Canadian General Insurance Company
The Canadian Surety Company
Commercial Union Assurance Company of Canada
Co-operators General Insurance Company
The Dominion of Canada General Insurance Company
Guardian Insurance Company of Canada
Liberty Mutual Insurance Company
Royal Insurance Company of Canada
State Farm Mutual Automobile Insurance Company
Wellington Insurance Company.

These carriers connect the Facility Association residual pool and the consumer. Each Ontario broker who wishes to provide service to residual market risks is assigned one of the 11 carriers. A broker writing Facility Association risks earns a commission which has now been capped by the Superintendent of Insurance. Servicing carriers are reimbursed for operating, servicing and claims adjusting costs.[11]

The Facility Association's profits and losses are shared by all insurers. The Facility Association underwrites both private passenger automobiles and commercial vehicles (taxis, couriers, leasing operations, long-haul truckers, etc.). As of August 1987, 1.7% of private passenger motor vehicles in Ontario were insured through the Facility Association, which will accept any risk, regardless of how bad it is, but will charge higher than market premiums and will, where relevant, levy appropriate surcharges. If the owner of a motor vehicle is entitled by law to drive, the Facility Association will provide coverage.

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[11] Facility Association, 1986 Annual Statement.

The Facility Association provides the residual market for all provinces except Quebec,[12] Manitoba, Saskatchewan and British Columbia where compulsory insurance is supplied through public monopoly. As of its 1986 year end (October 31, 1986), the Facility Association showed a deficiency of expenses over revenue of $29.6 million. Ontario's losses equalled 52% of the total Canadian losses, or more than all the other provinces combined. Ontario accounts for 71.85% of Facility Association written premiums.[13]

Facility Association premium rates are subject to the approval of the Superintendent of Insurance, as provided in section 10 of the Compulsory Automobile Insurance Act;[14] rate filings are not rubber stamped. The Facility Association rate filing made for January 1, 1987, sought rate increases of 23.2% for private passenger motor vehicles and 13.1% for commercial vehicles. Upon reviewing the Facility Association's application, the Superintendent of Insurance concluded that the rate increases sought were unacceptable and the Facility Association rate filing was withdrawn. Lower rate increases were subsequently approved.

Facility Association private passenger basic premiums are about 205% of the weighted average standard market

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[12] There is a residual market in Quebec where vehicle damage coverage is compulsory and provided by the private sector.

[13] Facility Association, Financial Statement for year ending October 31, 1986.

[14] R.S.O. 1980, c. 83.

premiums. Its premiums for private passenger motor vehicles are based upon the classification system used in the regular market.[15] The Facility Association also imposes premium surcharges including surcharges based on convictions.

Table 4.2 below sets out a breakdown of claims costs in the Facility Association. The significance of age is apparent.

TABLE 4.2

FACILITY ASSOCIATION

POLICYHOLDER CLASSIFICATIONS AND CLAIMS COSTS[16]

Classification	1985 Claims Cost per Car Insured for Liability Insurance
Adults, pleasure use only	$ 249.93*
Business cars	350.42*
Single male drivers aged 16 to 18	1,255.80*
Policyholders 5 years claims-free	258.16*
Policyholders 1 year claims-free	479.39*
Policyholders in Toronto	342.42
Policyholders in Northwestern Ontario	178.93

*taken from the experience for all urban territories combined.

The development of the Facility Association's share of the market by vehicles and premium in Ontario can be seen from Table 4.3 below:

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[15] This means Facility Association premiums are based on age, sex and marital status, among other things.

[16] Insurance Bureau of Canada, Automobile Insurance Experience, ("The Green Book"), 1985.

TABLE 4.3

FACILITY ASSOCIATION SHARE OF MARKET 1982-1986[17]

ONTARIO

	1982	1983	1984	1985	1986
BY VEHICLES INSURED (Third Party Liability)					
Private Passenger	2.0	2.5	1.9	1.5	1.7
Farmers (private passenger)	.5	.9	.9	.8	.8
Motorcycles	22.9	30.3	20.6	15.8	9.7
Snow vehicles	2.7	7.2	8.3	7.3	7.2
Commercial	1.9	2.8	2.3	1.8	3.5
BY PREMIUM (Third Party Liability)					
Interurban	5.9	11.4	6.2	3.3	23.5
Taxis	10.8	24.4	19.2	14.5	46.0
Public buses	1.7	4.3	2.6	4.1	15.1
School & hotel buses	2.4	2.8	2.5	2.2	2.3
Funeral & ambulances	2.6	-	.3	5.3	10.1
Miscellaneous public	.1	3.8	2.7	5.5	7.8
Garage	1.9	3.8	3.8	3.7	7.6
Garage legal liability	1.5	3.9	3.8	2.4	4.1

Surprisingly, 28.79% of Facility Association drivers are five-year claims-free drivers; 80.79% of those insured through the voluntary market are five-year claims-free drivers. 10.13% of Facility Association drivers had claims in 1985, as compared to 2.01% of all drivers insured through the voluntary market.[18]

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[17] The Green Book, The Grey Book (Facility Association Automobile Experience), 1986.

[18] Facility Association, "Presentation to Task Force on Insurance in Ontario" (February 26, 1986), p. 18.

Table 4.4 shows how different in character the Facility Association and regular market private passenger automobile risk pools are.

TABLE 4.4

CLAIMS HISTORY COMPARISON[19]

Facility Association % of Total	Claims History	Total Industry % of Total
28.79	5-year claims-free	80.79
44.55	3-year claims-free	13.46
7.00	2-year claims-free	1.81
9.54	1-year claims-free	1.94
10.13	0-year claims-free	2.01

The Facility Association's business for all motor vehicles other than private passenger automobiles has increased for a number of reasons. The provincial government's "Spills Bill" and the United States Commerce Commission requirement that certain long-distance haulers have a minimum of $5 million of third party liability coverage are examples of statutory and regulatory provisions which have led to an increase in the commercial population of the Facility Association. Further, a number of United States insurers which provided the required coverage on a fronting policy basis have withdrawn from the market leaving some Ontario commercial risks without the required United States coverage. The insolvency of the United Canada Insurance Company, an insurer providing coverage for many inter-urban haulers, temporarily placed many of those risks in the Facility Association; regular market coverage is now becoming available for a number of them.

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[19] Facility Association, "Presentation to Task Force on Insurance in Ontario," (February 26, 1986), p. 19.

Applicants for private passenger automobile insurance who are insured through the Facility Association should be limited to those who have been denied coverage in the standard or substandard markets. There are, however, instances of brokers placing risks in the Facility Association without having made any real attempt to secure standard or substandard market coverage.

Although I have encountered examples of insureds in the residual market who should not be there, it is clear that the loss experience of the 1.7% of Ontario private passenger drivers who are insured through the Facility Association is dramatically different from the loss experience of the regular market. Table 4.5 provides a comparison of Facility Association and regular market loss costs per car insured from 1981 through 1985.

TABLE 4.5

THIRD PARTY LIABILITY[20]

LOSS COST PER CAR INSURED

Facility Association		Total Industry	
Year	Average Loss Cost ($)	Year	Average Loss Cost ($)
1981	613.26	1981	180.68
1982	591.87	1982	182.48
1983	654.71	1983	203.28
1984	781.05	1984	241.68
1985	973.46	1985	284.65

Taxis present a problem which, in Toronto, can be described as ranging from difficult to impossible. I will discuss taxis later in more detail; for now, I simply note

[20] The Green Book, 1985.

that the loss experience for Toronto fleet taxis is so bad, even with the substantial Facility Association premiums, that taxi risks are almost uninsurable.

The enormity of this problem has been recognized by the Metropolitan Toronto Taxi Association; in its brief and oral submission to this Inquiry the Association proposed government-delivered, no fault insurance. As one member of the Metropolitan Toronto Taxi Association delegation put it, any private sector insurer which was considering insuring taxis first had to decide whether that part of the insurer's operation was a business or a philanthropic exercise. The Metropolitan Toronto Taxi Association's recommendation of government insurance was based on the premise that only the government could subsidize taxis in the circumstances. This is a precarious basis upon which to proceed to government insurance.

The majority of taxis in Toronto are now insured through the Facility Association. In 1985, 3.6% of Toronto territory taxis were insured through the Facility Association.[21] In 1986, 50.3% of Toronto territory taxis were insured through the Facility Association.[22] The dramatic increase in the Facility Association's taxi business can be seen from Table 4.6.

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[21] Facility Association, "Presentation to the Metro Toronto Licensing Commission," (June 22, 1987).

[22] Facility Association, "Presentation to the Metro Toronto Licensing Commission," (1987).

TABLE 4.6

TAXICAB INSURANCE[23]

ONTARIO AND TORONTO RATING TERRITORY

FACILITY ASSOCIATION SHARE	TOTAL MARKET	TORONTO ONLY
1982	10.8%	1.9%
1983	24.4%	8.4%
1984	19.2%	3.8%
1985	14.3%	3.6%
1986	45.7%	50.3%

Total market - 1985	$14,535,576 Actual
Facility Association share	$ 2,075,467 Actual
Total market - 1986	$18,090,515 Estimated
Facility Association share	$ 8,267,123 Actual

The regular market has simply stopped writing taxi business except for owner-operated taxis and, in some circumstances, co-operative taxis. This decision is justifiable with regard to fleet taxis operated in Metropolitan Toronto. In the Toronto rating territory, the Facility Association 1986 taxi premium income for all coverage was $3.75 million. Claims were $5.46 million. The three-year period extending from 1984 to 1986 presents an equally bleak picture. In that period, premiums were $19.6 million; claims were $38.37 million. The accident benefits coverage results were worse. In the 1984 to 1986

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[23] Facility Association, "Presentation to the Metro Toronto Licensing Commission," (June 22, 1987).

period, accident benefit premiums were $464,543; accident benefit claims were $4,565,308 or 983% of premiums.[24]

Finally, Table 4.7 shows the total deficit in the Facility Association for 1982 through 1985.

TABLE 4.7

FACILITY ASSOCIATION DEFICIT

Year	Amount of Deficit
1982	$14,986,000
1983	$32,485,000
1984	$44,304,000
1985	$39,868,000

It is apparent that Ontario drivers insured in the regular market are subsidizing, through their premiums, those insured in the Facility Association. I will return to this issue of cross-subsidization later in the Report.

B. MARKETING

About 74% of automobile insurance sold in Ontario, measured by premiums, is provided through independent brokers. Brokers are licensed under the Registered Insurance Brokers Act (R.I.B.O. Act).[25] Virtually all of the remaining 26% of automobile insurance is marketed through direct sales agents, who are almost invariably employees of an insurer and are regulated under the

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[24] Facility Association, "Presentation to the Metro Toronto Licensing Commission," (1987); "The Green Book," 1986.

[25] R.S.O. 1980, c. 444. The definition of insurance broker is found in Section 1(1).

Insurance Act.[26] Agents (as distinct from brokers and direct sales agents) have a minimal involvement in the sale of automobile insurance. Some insurers use both brokers and company-employed sales agents.

The Insurance Brokers Association of Ontario (I.B.A.O.) and the Toronto Insurance Conference (T.I.C.) represent the collective interest of most Ontario brokers. There are, however, a considerable number of brokers who do not belong to either organization. Those brokers are somewhat cut off from the information supplied by the I.B.A.O. and T.I.C. Although there are obvious advantages to association membership, I do not think brokers should be required to belong to any specific organization, including the I.B.A.O. or the T.I.C. Both the I.B.A.O. and T.I.C. are involved in education programs that need not be detailed here. This is to be encouraged.

The Registered Insurance Brokers of Ontario (R.I.B.O.) is the broker's licensing and disciplinary body. I did not regard a review of R.I.B.O.'s licensing function as being within my mandate; therefore, I will not comment on the extent to which unqualified brokers may be licensed under the R.I.B.O. Act except to say that the issue should be examined and monitored. R.I.B.O. is also responsible for disciplining brokers. A review of this part of R.I.B.O.'s undertaking suggests that the most common problem requiring disciplinary intervention is the misuse of trust funds by brokers.

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[26]R.S.O. 1980, c. 218. The definition of agent is found in Section 1.5.

R.I.B.O. does not monitor those insurers that individual brokers represent nor does any other regulatory body record what companies are represented by what brokers at any given time. This should be corrected. Some control mechanism must be established, at least to identify brokers who represent no automobile insurer other than a Facility Association servicing carrier.

Brokers selling automobile insurance along with other lines of insurance are located throughout Ontario. There are few communities of any significant size that do not have a local business person engaged in selling general insurance.

A broker may represent any number of regular market automobile insurers. Almost every broker has also accepted the assignment of a Facility Association carrier, thereby giving the broker and his or her customers access to the residual market. The contracts between insurers and brokers are not uniform, although there are typical provisions in every agreement.[27]

Although brokers exercise independent judgment in entering into contractual arrangements with insurers, once an insurer-broker relationship is established, the broker is subservient to the insurer's underwriting policies, and of course, the insurer's rate manual. Premiums received by a broker are held in trust for a 60 to 90-day period. These premiums less the broker's commission are then forwarded to the insurer.

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[27]For a typical contract between an insurer and a broker, see Appendix XIII.

Brokers provide these general services for insurers and consumers:

(1) receive applications for automobile insurance;
(2) exercise underwriting discretion;
(3) accept premium payments or partial premium payments and deposit these payments in trust;
(4) establish insurance policy records for applicants including policy expiry dates;
(5) inform consumers about optional coverage in the following areas:
    (a) bodily injury/property damage limits in excess of the statutory minimum of $200,000;
    (b) collision coverage and the appropriate deductible;
    (c) comprehensive, specified perils and all perils coverage, and the appropriate deductibles;
    (d) uninsured motorist coverage (now SEF 44) (included unless the consumer specifically rejects it);
    (e) any other endorsement coverage;
(6) receive claims information, assist the insured with respect to claims and transmit claims information to the insurer when required.

A consumer dealing through a broker secures access only to those companies the broker represents. That access may be limited to one company, other than a Facility Association servicing carrier, or may extend to a relatively large number of companies. Typically, brokers may represent from three to six insurers. In early 1987

the Superintendent of Insurance prohibited brokers from representing only a Facility Association carrier. This practice had denied the unsuspecting consumer access to the standard or substandard markets. A broker may still represent only one regular market insurer and a Facility Association carrier.

Usually the consumer leaves the decision as to the choice of insurer to the broker. Price is the dominant consumer consideration. Inquiry hearings and miscellaneous consumer inquiries have led me to the conclusion that the consumer/broker contact, as related to automobile insurance, is usually initiated by the consumer, and brokers are often selected without regard to the companies they represent. Most brokers do not advertise or volunteer information on the insurers they represent.

In many instances, consumers are aware of their broker's name, but do not know the name of their automobile insurance company. Consumers dealing with direct writers are more often aware of their insurer's name, but are less likely to recall the name of the agent through whom the insurance was purchased.

The delivery of automobile insurance through brokers is, to say the least, entrenched. Brokers have become an integral and important part of Ontario communities, big and small. There are, however, obvious problems with the system. Very few brokers have come forward to assist in the process of identifying or resolving these problems. Individual brokers have been helpful, but only when asked. As brokers are, and will likely continue to be, an integral part of the automobile insurance delivery system,

it is vital that structural weaknesses in the delivery system be repaired.

I think the relative silence of brokers as to existing problems is best explained by the simple observation that independent brokers are not independent once under contract to an insurer. At that point brokers are largely dependent for economic survival on the insurers they represent.

Brokers' commissions vary significantly. Each company has its own commission policy although commissions generally range between 7.5 and 20% of gross premiums. Commissions average about 12%. The larger the premium, the larger the commission. As surcharges are imposed, following an at-fault accident for example, the broker's commission increases. The quantum of the broker's commission is almost never disclosed to the consumer; the consumer knows neither the commission rate nor the variation in commission rates among insurers the broker represents.

Insurers regularly provide incentives and rewards to their brokers. Trips to Hawaii and commission bonuses for reaching a certain volume of business are two examples. Profit sharing incentive plans are also common. One major insurer includes brokers who sell a certain volume of insurance in its pension plan.

The established insurer/broker structure reeks of conflict. The broker often chooses one insurer over another in consideration of a number of factors unknown to the applicant for automobile insurance. For example, incentives provided by an insurer or volume of business

requirements imposed by an insurer may affect the selection process from a broker's standpoint.

Although price is the dominant consumer concern, the broker has no obligation to disclose and often does not disclose any competitive premiums, even among those insurers represented by the broker. The result is that in many instances the consumer has limited information about premiums of the broker's other insurers, and no access to information about companies not represented by the broker. The consumer is generally not informed of individual company surcharges and accident forgiveness policies. The insurer's capacity to provide customer service is a matter of concern to some, but not many consumers. When the issue arises, the broker must rate the companies he represents on the basis of customer service.

Brokers' contractual arrangements with insurers are fragile, in the sense that the broker's right to represent an insurer can generally be terminated on relatively short notice. The termination notice period is always provided for in insurer/broker contracts (even if no notice is required). Termination can have a detrimental effect on both the insured and the broker. This has not been a problem for some months because of a 12-month moratorium on broker cancellation declared in December 1986. The moratorium arrangement was entered into by the Insurance Bureau of Canada (I.B.C.) and the Insurance Brokers Association of Ontario (I.B.A.O.). It is interesting to note that this truce coincided with the commencement of this Inquiry and will end at about the time the Inquiry ends. The moratorium on broker cancellation by insurers is obviously not a long-term solution.

There is no doubt that in many instances the cancellation of brokers by insurers is a perfectly reasonable exercise of sound business judgment. Few would argue that an insurer should be forced to remain contractually bound to a dishonest broker; however, brokers are often cancelled for less acceptable reasons. An insurer's termination of its contractual arrangements with brokers typically arises as a result of:

(1) poor loss ratio;
(2) unacceptable mix of business (for example, too few homeowners' policies compared to the number of automobile policies);
(3) the failure to satisfy insurers' accompanying business requirements. In the automobile context, the accompanying business requirement imposes an obligation on the broker to obtain other business from the same insured (e.g., a homeowner's policy) before accepting the insured's automobile business;
(4) unacceptable balance of business (this is the mix of business issue, but assessed from a premium, not a policy, standpoint);
(5) inadequate volume of business.

There are, of course, other reasons that an insurer may see fit to terminate a broker's contract having nothing specifically to do with the broker's activities - for example, solvency rules requiring the insurer to maintain a sufficient surplus to premium ratio may require an insurer to terminate brokers.

When a broker's contract with an insured is terminated by the insurer, there is little problem for the consumer

if the broker can arrange coverage with another insurer without an increase in premium. Too often, brokers are unable to arrange this alternate coverage. The problem is particularly acute for insureds who have had accidents within the preceding five years. Other companies are reluctant to assume those risks and if they do, the insured often faces a lower rating and increased premium. I have also been told that following a broker's termination it is difficult to place insureds without accident or conviction records if they happen to be under 25, male, unmarried and if their motor vehicle happens to be what insurers regard as a high risk vehicle.[28] Some insurers will not take on an under-25 unmarried male no matter what type of automobile he drives. The cancellation of a broker may force the insured to "shop". Although "shopping" has been explicitly encouraged, it is only a viable option for those without blemishes on their driving record.

Shopping generally cannot be done by telephone; it requires the applicant's physical presence at the broker's or agent's office. This is time-consuming and effectively limits the consumer's ability to make an informed choice when buying automobile insurance.

No rigid judgments can be made as to the legitimacy of the reasons why insurers terminate their contractual arrangements with brokers. The most suspect reason is loss ratio. A high loss ratio, as assessed within a very small group of insureds over a short time period, may be

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[28] These cars generally fall within the description of sports cars. The most common anecdotal reference is to a Corvette.

the result of one or two accidents. Termination of the broker's right to sell insurance for a company in such circumstances is unfair. Unless the broker's loss ratio is measured over an extended period and demonstrates that the broker is accepting business that should not have been underwritten, or is ignoring company underwriting policies, a poor loss ratio is as much attributable to bad luck as bad underwriting by the broker.

If a broker is cancelled on the basis of volume of business, cancellation is almost always preceded by advice from the insurer that it cannot continue to do business with the broker at the established level. This places the broker in an impossible position of conflict. Unless the broker can encourage more people to insure through that company, the broker will lose the right to sell automobile insurance for the insurer. The consumer's best interests may well become submerged in the process. On the other hand, in a free market system, it does not make sense to require an insurer to maintain a contractual relationship with a broker that results in a volume of premium income that is so small as to make the arrangement unprofitable and administratively inefficient. No hard and fast rules can be established, but I will shortly make some recommendations concerning the rights of consumers affected by broker cancellations.

When an applicant for insurance obtains coverage through a direct writer, the consumer deals with what is often referred to as a "captive agent".[29] A consumer

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[29]This term is commonly used in the insurance industry to describe employees of direct writers who sell insurance to the public. The Ontario Task Force on Insurance Report adopted this term for agents selling for direct writers.

dealing with a captive agent has the benefit of knowing at the outset what company contact is being made. The difficulty, from the consumer's standpoint, is that any dealing with a captive agent provides consumers with access to one company and no more. If an applicant for insurance wants information concerning what insurance with another company will cost, he or she has to check with a broker or another captive agent.

On the basis that the current delivery system will be subject to relatively minor structural modifications, I make these recommendations:

1. The consumer must be given better access to information on available premiums.[30] Because of the fragmented delivery system, this access must come, at least in part, from outside the system. In Michigan, the consumer information problem is dealt with by the State Insurance Office's publication of typical insurance premiums in the same way (but with less frequency) as mortgage rates are made known to the public. I recommend that at regular intervals throughout the year, the Office of the Superintendent of Insurance publish basic rates of automobile insurance to ensure province-wide exposure.[31] The consumer should also be informed about typical surcharges.

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[30] Ontario Task Force on Insurance, Final Report (1986); Select Committee on Company Law, Third Report (1979); Ontario Law Reform Commission, Report on Motor Vehicle Accident Compensation (1973).

[31] A typical Michigan premium availability notice can be seen in Appendix XIV.

How this information should be assembled can best be considered once decisions have been made as to the existence and form of rate regulation. If the Ontario Government's proposed system of rate regulation is introduced, premium differentials among insurers will be very much narrowed. If that happens, the consumer's access to premium information may simply be accomplished by the publication of the range of rates established by the Ontario Automobile Insurance Board within the prescribed classification system. The more regulated the rates, and the simpler the classification system, the easier it will be to provide the consumer with this necessary information. However this is accomplished, it is important that the public be made aware of what premiums are available.

2. Brokers and agents (most often employees of direct writers) should be required to display prominently the names of insurers for whom they act.

3. Each broker should clearly identify his or her Facility Association servicing carrier.

4. All brokers should be required by statute to provide access to the residual market (the Facility Association) through a designated servicing carrier.

5. Notwithstanding termination provisions contained in contracts between insurers and brokers, in cases other than fraud, dishonesty, etc.,

insurers should be required to give some minimum notice of termination to brokers. Many contracts between insurers and brokers provide for no notice of termination. My concern is not so much with the broker, but with insureds who may be inconvenienced and subjected to increased premiums as a result of an insurer's decision to terminate its contractual relationship with the broker. The minimum notice period should be examined through consultation between insurers and brokers. I am inclined to the view, but stop short of making a specific recommendation, that the minimum notice period be 90 days and that for broker/insurer contracts in place for more than five years, the period be 120 days.

6. Insurers terminating contracts with brokers should be required to give specific reasons for the termination. An arbitration structure through the I.B.C. and I.B.A.O. to deal with broker/insurer disputes, including terminations, should be established.

7. An insurer terminating its contract with a broker because of mix, balance or volume of business, or loss ratio, should be encouraged to enter into a rehabilitation program with the terminated broker. In many American jurisdictions, rehabilitation programs are mandatory. It seems to me that there are too many variables to make rehabilitation programs mandatory, and I stop short of making that recommendation. Instead I recommend that the automobile insurance companies and brokers, together with the Superintendent of

Insurance and R.I.B.O., enter into discussions to establish guidelines for the use of rehabilitation programs, particularly when loss ratio is the basis of an insurer's decision to terminate its contract with a broker. If, after a rehabilitation program has been established, the insurer terminates the broker, notice of the termination should refer to the rehabilitation program and its lack of success.

8. Given the marketplace stigma attached to insureds who have been terminated by an insurance company, care must be taken not to structure a solution which will create incentives for insurers to terminate insureds individually. It is bad enough for an insured to be subjected to the problems associated with a broker cancellation; it is worse to be subjected to the stigma attached to individual termination.

There is no problem for insureds who are placed with another company at no increase in premium. The problem lies with anyone who would not have faced an increased premium but for the broker's cancellation.

While I have grave concern for consumers adversely affected by broker termination, it is easier to identify the problem and the concern than it is to structure the solution. It has been suggested that one solution is to mandate one automatic renewal. This has a simplistic appeal to it. However, it ignores the fact that apart from the broker cancellation, when the

insurance contract is at an end, the insurer has no more obligation to the insured than the consumer does to the insurance company. It also ignores the fact that valid reasons may arise, either before or after the broker termination, that justify non-renewal of the insurance contract.

Fundamental to any solution is the disclosure of the facts. Beyond that, it is generally thought that brokers acquire a proprietary interest in the business of the insured. Assuming that to be correct, it would follow that the broker owes a duty of full disclosure to his client. I therefore recommend that upon a broker cancellation, the broker should be obligated to inform the insured that he is no longer acting for that particular company and that if the consumer wishes to continue with that company, the consumer should contact the company to obtain information about other brokers writing its business.

9. The I.B.C., in conjunction with the Canadian Federation of Insurance Agents and Brokers Association, has attempted to address this general problem area by prescribing guidelines for broker terminations. An edited version of these guidelines is as follows:

   (1) Where an insurer intends to withdraw from a province or an area within a province or intends to terminate a broker and accordingly does not intend to renew its policies in that province or area or with

that broker, it shall give 90 days' prior notice in writing to its broker, if any, and

a. where the broker, being an appointed representative of one or more other insurers, has a market for and undertakes to replace the policies, he shall, within 15 days of receipt of such notice, inform the terminating insurer in writing of his undertaking to do so, whereupon the agent shall assume responsibility for advising each insured at least 30 days prior to the policy expiry date; or

b. where there is no broker or where the broker is not an appointed representative of another insurer or where the broker does not, within the said 15 days, undertake in writing to replace the policies as provided in sub-clause (a), the terminating insurer shall notify the insured in writing at least 30 days prior to the expiry date of each policy to be lapsed.

(2) Where for reasons other than the foregoing, an insurer does not intend to renew a specific policy, the insurer shall give 60 days' prior notice in writing to its broker, if any, and otherwise notice shall be given in accordance with Clause (1).

(3) Where a broker of his own volition or at the request of an insured, decides to replace an expiring policy with similar

> coverage with another insurer, the broker shall notify the existing insurer in writing of such decision, returning the renewal document, if any, and shall advise the insured prior to the policy expiry date.

I endorse these guidelines. The Superintendent of Insurance should carefully monitor broker terminations to ensure these guidelines are being followed and to ensure that insureds will not be unfairly affected by having to pay increased premiums as a direct result of the insurer's termination of a broker. An insured should not be adversely affected by issues having relevance only to a broker and an insurer.[32]

10. A breakdown of an insured's automobile insurance premium payment, including the broker's commission, should be provided in all cases. This breakdown should identify premium payments for coverages purchased in plain understandable language. Assuming the automobile policy structure remains intact, the breakdown should include:

    (i) Section A premium;
    (ii) Section B premium;
    (iii) Section C premium (including the specific coverages secured);

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[32] The guidelines referred to above were circulated among I.B.C. members on September 9, 1987.

(iv) the premium for each endorsement coverage purchased; and

(v) the broker's commission expressed in both percentage terms and dollars.

Brokers have steadfastly and consistently resisted disclosing their commissions. The most common argument advanced against commission disclosure is that others in the sales field are not required to disclose their commission. Individual brokers and the I.B.A.O. cite used car salesmen and sales clerks in retail stores as examples of those who are not required to disclose their commissions. It seems to me that whether or not a used car salesman is required to advise the consumer of the commission he is making on a deal can hardly set the standard. Brokers lay claim to professionalism and are self-regulating. Other self-regulated professions are required to disclose their fees. When the consumer is purchasing what, for the most part, is a compulsory product (Sections A and B of the automobile policy) the consumer is entitled to know what he or she is paying for. The fact that the consumer may be encouraged to ask a few more questions, some of which may specifically relate to the broker's commission, is something which I view as healthy, not something to be discouraged. I note that

regulations under the R.I.B.O. Act may require that brokers' fees be disclosed.[33]

11. The Superintendent of Insurance has imposed a cap on brokers' commissions for risks written through the Facility Association. For private passenger automobiles, the commission cap is $150.00. The broker's Facility Association commission is disclosed, but is misleadingly referred to as a Facility Association fee. That would suggest to most consumers that the payment is in the nature of a charge levied by the Facility Association and not the broker. That should be corrected. Alternatively, the cap should be removed and the Facility Association commission lowered. In either event, the commission should be disclosed to the consumer.

12. Since shopping has been encouraged, and insurers recognize the public's need to know available premium rates, brokers should be required, or at least encouraged, to give premium quotations by telephone. Recognizing that certain underwriting information may not be available in a relatively brief telephone interview, these quotations should be non-binding. The broker should, if asked, identify those companies that the broker represents. Access to premium information by

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[33]O. Reg. 637/81, 5-13. The section requires that the broker's fee be disclosed "where a member proposes to charge a fee for service in addition to retaining a portion of the premium charge." R.I.B.O. takes the position the section does not apply to the broker's basic commission.

telephone is important in rural areas, particularly in Northern Ontario where great distances may have to be covered.

13. The R.I.B.O. Act should be amended to specifically prohibit any broker from acting only for a Facility Association servicing carrier. Abuses in this area have been reduced, but probably not eliminated. The Superintendent of Insurance, through R.I.B.O., has implemented a policy prohibiting brokers from acting only for the Facility Association. To ensure compliance, this policy should be the subject of legislation. There is no place for a broker who provides the consumer with access only to the residual market.

14. Banks and trust companies should be entitled to market automobile insurance. This will enhance competition and make automobile insurance available throughout the province. Banks and trust companies are obviously equipped to handle trust monies and will be able to provide the advice that is necessary to sell automobile insurance.

15. Regulations under the R.I.B.O. Act prohibit part-time brokerage activity unless approval is obtained through the Qualification and Registration Committee. There are, in fact, many part-time brokers in Ontario whose part-time activity has not received the approval of the Qualification and Registration Committee. Part-time brokers fulfill a need, particularly in rural areas. The whole concept of prohibiting

part-time activity should be re-examined. In my opinion, the emphasis on making insurance available to consumers, as opposed to reinforcing existing vested interests, should be reinforced.

16. Insurers use a variety of underwriting criteria in exercising a decision as to whether a risk will be underwritten. Some insurers take into account the number of occasions, within a given period (typically three or five years), the applicant for insurance has changed insurers. This obviously discourages shopping; it limits true freedom of choice and deprives the applicant of the full benefits of competition. I recommend that insurers be prohibited from using it as an underwriting criterion. This kind of underwriting practice should be deemed to be unfair and subject to penalty. Unfair claims and underwriting practices will be dealt with in Chapter 13 of this Report.

17. Insureds having a claim against a negligent broker should not be denied compensation from the broker's liability insurer because of policy violations such as the broker's failure to report the claim. The emphasis should be on the equities as between the insured and the broker.[34]

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[34] See Section 106 of the Insurance Act, R.S.O. 1980, c. 218; see also Perry v. Gen. Security Ins. Co. of Canada, 47 O.R. (2d) 472. (A case involving a negligent solicitor who failed to report a claim, with the result that the plaintiff's action against the solicitor's insurer failed).

CHAPTER 5

COVERAGE AND DELIVERY PROBLEMS

A. COVERAGE

The car became established as a major presence in North America in the early 1900s. Injuries and property damage were an immediate consequence. From the beginning, insurance was relied upon to compensate people who suffered loss as a result of the use or operation of a motor vehicle. Problems were soon recognized. In May 1919, this excerpt from a letter to the editor appeared in a Massachusetts newspaper:

> At present, in an effort to redress the wrongs of one who suffers from an accident, the law allows a suit to be brought. This means that the plaintiff must locate witnesses and prove negligence. Both may be difficult or impossible. A law case drags along in court for a year or two, the expenses of lawyers, and of the physicians who testify as to the damages, are large and meantime the victim very likely lacks money when he most needs it. If he is poor, the lawyer has to advance the necessary expenses and he will never get them back, or get anything for himself, unless he settles or wins the case. As it is always uncertain whether he will win, he is under temptation to settle, even for an amount less than the plaintiff ought to have. The refinements that have grown up in the law as to negligence and contributory negligence are hard to understand; they afford grounds for appeals and new trials, and bear only a slight relation to the needs of the situation. In case a judgment is obtained, it may be impossible to collect it, because many people and corporations who run automobiles are financially irresponsible.[1]

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[1]Weld A. Rollins, "A Proposal to Extend the Compensation Principle to Accidents in the Streets," Saturday Evening Record, (Boston, Massachusetts) May 31, 1919.

Automobile insurance was added to the Ontario Insurance Act in 1914.[2] The Act was amended in 1922 to provide detailed provisions on automobile insurance and statutory conditions. In 1930 the Act was further amended to provide that it was the duty of the Superintendent of Insurance to adjust premiums if, after hearings were held, rates were determined to be "...excessive, inadequate, unfairly discriminatory or otherwise unreasonable".[3] This provision has remained in the Insurance Act since 1930 but it has never been proclaimed in force.

Ontario's automobile insurance coverage has always included bodily injury/property damage third party protection. This form of insurance indemnifies the insured from "liability imposed by law" arising out of the ownership, use or operation of the insured vehicle by anyone driving it with the express or implied consent of its owner. Any person driving the insured vehicle with the owner's consent is deemed to be a party to the automobile insurance contract; that person is referred to as an "unnamed insured" under the contract.[4]

In 1932, minimum bodily injury/property damage limits were established at $5,000. Insurance was not compulsory at that time. Nevertheless, anyone who did buy automobile

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[2] S.O. 1912, c. 33, as amended by R.S.O. 1914, c. 30.

[3] S.O. 1930, c. 41, s. 12. Now see Insurance Act, R.S.O. 1980, c. 218, ss. 370 and 371. Section 394 prohibits any person from engaging in "...any unfair or deceptive act or practice in the business of insurance." This section has apparently never been used to address unfair premiums.

[4] Insurance Act, R.S.O. 1980, c. 218, s. 213.

insurance had to purchase third party bodily injury/property damage coverage of at least $5,000.

In 1957, the minimum limits were raised to $10,000 per person injured in an accident, subject to an overall limit of $20,000 per accident. The minimum limits were increased to $35,000 in 1966, to $50,000 in 1968, to $100,000 in 1977 and to $200,000 in 1981. Ontario's minimum limits for bodily injury and property damage remain at $200,000.

Minimum limits mean little for a person injured in a motor vehicle accident as a result of another person's negligence, if the defendant wrongdoer has no insurance or assets with which to satisfy the injured person's claim. The first direct response to this problem occurred in 1947. The Highway Traffic Act was amended so as to establish the Unsatisfied Judgment Fund.[5] All licensed drivers paid a stipulated amount to finance the fund. The fund was a source of compensation for plaintiffs awarded damages arising out of motor vehicle accidents if they could not recover money from the owner/driver of the at-fault vehicle either because the owner/driver was unknown or unidentified or impecunious. Bodily injury damages were restricted to the prevailing minimum limits.

In 1962, access to compensation for those not having access to third party insurance or a defendant with assets was provided by the Motor Vehicle Accident Claims Fund.[6]

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[5] S.O. 1947, c. 45, s. 16.

[6] The Fund was created by an Act Respecting Claims for Damages Arising Out of Motor Vehicle Accidents, S.O. 1961-1962, c. 84.

The Fund replaced the Unsatisfied Judgment Fund and was differently financed. Each owner of a motor vehicle had to establish that the vehicle was insured, or if uninsured, that the required fee had been paid. The Fund still exists but its significance has diminished with the advent of uninsured, unidentified motorist coverage, now part of Section B of the standard automobile insurance policy. The Fund now responds to relatively few claims. As can be seen from Table 5.1, the Fund's business has declined dramatically since the 1978-1979 fiscal year when there were 10,097 claims made against it.

TABLE 5.1

CLAIMS AGAINST THE MOTOR VEHICLE ACCIDENT CLAIMS FUND

Fiscal Year	No. of Claims	Payments
1978-79	10,097	$15,941,756.83
1979-80	7,955	16,658,628.85
1980-81	2,671	14,469,524.91
1981-82	1,207	11,830,172.46
1982-83	1,083	13,527,392.36
1983-84	1,259	9,641,042.42
1984-85	813	5,974,868.64
1985-86	706	3,723,423.37

In 1979-1980, $16,658,628.85 was paid out of the Fund. In 1985-1986, the Fund payout was $3,723,423.37. The most common example of the need for the Fund is a pedestrian case in which the injured pedestrian is not at fault and has no access to any automobile insurance policy.

B. THE STANDARD FORM AUTOMOBILE INSURANCE POLICY (1987)[7]

Inquiry hearings and submissions have confirmed the existence of a number of problems within the insurance-compensation system. The most common complaints were about the underwriting practices of some insurers. Failure to provide Section B, no fault benefits, particularly disability benefits (income replacement) and rehabilitation benefits, is also an obvious area of concern. Unrest about the adequacy of third party compensation was minimal. In fact, many of those making submissions to this Inquiry or attending its hearings, expressed shock at what they thought were inordinately high damage awards. Most of those concerned about high damage awards relied on anecdotal evidence. Nevertheless, there is a pervading belief that the injured eligible for compensation through tort law are compensated too generously.

In dealing with problems in the insurance-compensation system, I think it is sensible to start with the automobile insurance policy as a whole and then to deal with specific problems relevant to Sections A, B, and C of the policy.

The automobile insurance policy is divided into three sections. Two of the three sections deal with insurance coverage that is compulsory (Sections A and B). Section C (collision, comprehensive, all perils and specified perils) is optional, although collision and comprehensive coverages are widely purchased. Taken as a whole, the

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[7] See Appendix X.

standard form of automobile insurance policy is badly structured and incomprehensible.

For example, the automobile insurance policy contains general provisions, definitions and exclusions, which are supposed to, but do not apply to, the entire policy. Section B of the policy (the so-called no fault section) has its own general provisions, definitions and exclusions. Lest anyone reviewing Section B feel over-confident on that account, it is to be noted that Section B's general provisions, definitions and exclusions do not apply to that part of Section B which deals with the uninsured/unidentified motorist coverage. It is impossible for a consumer to read Section B of the policy and understand it.

Exclusions are sprinkled throughout the automobile insurance policy. From a consumer's standpoint, exclusions are matters of significance. There is little consistency in form, and limited consistency in substance, in the way exclusions are dealt with in the automobile policy. Exclusions applicable to Sections B and C appear in those sections of the policy; that makes sense to me. Exclusions applicable to Section A are not found in Section A, but in the general provisions, definitions and exclusions.

The Section B and C exclusions are puzzling in some respects. Exclusions in both sections purport to deal with the impaired driver. In Section C, which deals with vehicle damage, the exclusions include an insured who drives while under the influence of alcohol or drugs so as to be "incapable of the proper control of the automobile." Section C's exclusions go on to exclude coverage if the

insured is convicted of an offence under section 234, 236 or 235(2) of the Criminal Code of Canada. I assume the intent was to deny collision coverage to an insured who has wrapped his car around a tree and who has been convicted of any one of the offences commonly known as impaired driving, exceeding the authorized breathalyzer limit or refusing to take a breathalyzer test. The problem is that these offences are not referred to other than by Criminal Code section number. Two of the Criminal Code section numbers referred to deal with water skiing (section 234) and unseaworthy vessels (section 235), not cars and drivers. The other section referred to (section 236) deals with leaving the scene of an accident. Obviously, the sections of the Criminal Code have been renumbered, but identification of the exclusions has remained unchanged.

Section B's exclusions deny some first party no fault benefits to the insured convicted of drunken or impaired driving. The Section B alcohol-related exclusion does not include the insured who is convicted of driving while having a breathalyzer reading in excess of .08, or an insured who refuses to take a breathalyzer test upon lawful demand. I would have thought that if any no fault benefits are to be denied an insured who is convicted of impaired driving, it would be sensible and reasonable to also deny those benefits to an insured who is convicted of driving with a blood alcohol reading of more than .08 or an insured who refuses to take a breathalyzer test upon lawful demand. As matters now stand, if an insured wants access to first party no fault benefits, and if that insured has a choice, literally any conviction other than impaired driving will do. For example, an insured convicted of criminal negligence causing death will

receive no fault benefits. An insured convicted of impaired driving will not, even if the accident was not that insured's fault. I am told that the lack of symmetry between the Section C alcohol-related exclusions and Section B's exclusions is that when Section B was first drafted, the breathalyzer offences (blowing over .08 and refusing to blow) were not part of our criminal law.

The standard form of automobile insurance policy can be conveniently subdivided as follows:

(i) Third party liability protection with minimum limits of $200,000 or such increased limits as the insured decides to purchase. This protection includes an obligation requiring the insurer to defend any claim brought against the insured arising out of the insured's ownership, use or operation of the motor vehicle.

(ii) Section B of the policy provides so-called no fault benefits which include work-related economic compensation to a maximum of $140 a week. Homemakers are modestly provided with $70 a week maximum, subject to a 12-week limitation. Medical, hospital, rehabilitation and retraining expenses are paid through Section B subject to a $25,000 four-year limitation; those who are already covered under O.H.I.P. have all medical/hospital expenses paid without any limitation. Modest death and funeral benefits are provided.

(iii) Section C of the policy provides vehicle damage (collision) coverage. This is first party

coverage subject to an agreed deductible. It provides protection against damage occurring as a result of collision or upset and, if agreed to, additional coverage such as comprehensive, specific perils and all perils. This coverage is not compulsory.

(iv) The entire policy is subject to Statutory Conditions. These conditions, as the designation implies, are statutory and are part of the standard automobile policy. The Statutory Conditions apply in their entirety to Sections A and C of the policy. Only Statutory Conditions 1, 8 and 9 apply to Section B. The Statutory Conditions provide a general framework for the policy. The Statutory Conditions include the definition of insured under the policy; the application of Statutory Conditions to Section B; provisions with respect to change in risk; excluded uses by the insured; excluded uses by others; requirements imposed on the insured after a loss; provisions with respect to giving notice of a claim and proof of loss; provisions with respect to termination; and provisions with respect to the manner in which notice is required by the policy may be given.

(v) The automobile policy contains general provisions, definitions and exclusions. Most, but not all of these, apply to the policy as a whole. The general provisions, definitions and exclusions are not to be confused with the Statutory Conditions.

(vi) The policy also contains provisions applicable to each section of the policy. Section A's exclusions are contained within the general provisions, definitions and exclusions part of the policy. In addition to the general exclusions, Sections B and C contain their own exclusions.

(vii) Underinsured motorist exclusions are optional and provided through the SEF 44 endorsement. Uninsured/unidentified coverage (compulsory) is part of Section B, but for a structural analysis, this coverage can best be considered on its own.

(viii) There are provisions in the Insurance Act[8] falling outside the policy which affect the automobile insurance policy. The main statutory provisions requiring comment are the $200,000 minimum third party limits and the requirement that the third party insurer pay up to the minimum limit even if the third party insured is guilty of a policy violation.

(a) Section A (Third Party Liability)

Section A of the standard automobile policy protects the insured, or anyone operating the insured vehicle (the described automobile) with the insured's consent, from liability imposed by law as a result of causing injury or loss to others. The minimum limits of the protection afforded by Section A are $200,000. According to the Insurance Bureau of Canada, the average third party

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[8] R.S.O. 1980, c. 218.

liability protection secured by Ontario motorists is over $500,000. The insuring agreement requires the insurer to defend any action brought against the insured, to pay any judgment up to policy limits and to pay costs even if those costs result in a payment in excess of policy limits.

I propose here to deal with some existing problems related to Section A of the policy as it is presently structured. The significance of these problems and any proposed changes will, of course, depend upon changes in the compensation system and policy structure which may be implemented in the future.

As earlier noted, there were relatively few submissions and consumer complaints related to the resolution of bodily injury and property damage claims.[9] Several severely injured motor vehicle accident victims who attended Inquiry public hearings seemed pleased with the system that provided them with access to compensation and with their legal representation. Consumer complaints reviewed at the Office of the Superintendent of Insurance rarely involved third party bodily injury claims.[10]

Property damage claims (aside from relevant deductibles) are mostly resolved by insurers through the

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[9]There were complaints about rehabilitation. However, the third party system is not in general looked to as the source of funds for rehabilitation.

[10]Consumer complaints are logged by computer in the Office of the Superintendent of Insurance. Most involved underwriting-related matters.

fault chart.[11] I do not think consumers recognize the importance of the fault chart beyond its use in determining what part of the insured's deductible will be paid by the collision insurer. The fault chart, as its name implies, is used to determine fault on an arbitrary yet consistent basis. That fault finding leads to the insurer either paying or not paying a vehicle damage claim. If payment is made, the relevant accident becomes an at-fault motor vehicle accident for premium rating purposes. In the long run, premium implications of the application of the fault chart are often more significant than the question of whether an insured will or will not recover part of his collision deductible.

A further problem with the fault chart is that insureds have no real access to any dispute mechanism through which to challenge its allocation of fault. In Manitoba, for example, the allocation of fault by the Manitoba Public Insurance Corporation (M.P.I.C.) may be disputed by an insured through the M.P.I.C. directly, or through the Manitoba version of the Provincial Court (Civil Division).

Underinsured (SEF 44) coverage provides compensation where the wrongdoer's policy limits are inadequate. This endorsement coverage is purchased by over 90% of Ontario insureds.[12] Most brokers and direct writers sell SEF 44 coverage unless the consumer rejects it in writing. SEF 44 only has relevance in those cases where the insured

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[11] The fault chart is reproduced as Appendix XV.

[12] This information comes from the Insurance Bureau of Canada and was generally confirmed in discussion with insurers and brokers.

purchases more than the minimum third party limits ($200,000). SEF 44 premiums should not be reported under the Statistical Plan as part of Section B premiums, as is now being done.

Some have suggested the $200,000 minimum third party limits should be increased. There are those who recommend unlimited third party liability coverage. Others who support increasing the limits approach the issue by simply selecting a figure higher than $200,000. A number of jurisdictions have unlimited third party limits. Great Britain, for example, has no limit on third party liability. Insurers in Great Britain seem to encounter no problems with this unlimited third party exposure. If third party exposure were unlimited, transaction costs would be lowered; one insurer could respond to all third party claims without concern about policy limits;[13] the first party insurer would not be brought into the claim wearing its SEF 44 hat.

I do not think limits should be open-ended because of solvency considerations. With respect to increasing the limits, cost is a problem which cannot be ignored. Increasing limits will increase premiums. Further, some seem to have a serious problem obtaining automobile insurance now. I think of young male drivers as an example. Their problem will be exacerbated if insurers are forced to sell policies with no third party limits or substantially increased third party limits. On balance, it seems to me that the benefits attendant upon increased policy limits do not outweigh the costs. I therefore

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[13] The Superintendent of Insurance is among those who have recommended a limit be placed on all coverage exposures.

recommend that the $200,000 minimum limits continue. Those wishing to receive additional protection can do so by purchasing either additional third party liability coverage or SEF 44 underinsured coverage or both on an optional basis.

I gave serious consideration to recommending SEF 44 coverage be compulsory where an insured has purchased third party limits in excess of $200,000. In the final analysis, I concluded that this might encourage those insureds seriously concerned about cost to secure minimum third party coverage and thus avoid paying the SEF 44 premium. Moreover, almost everyone has SEF 44 coverage now; minimal gains would result from making the uninsured coverage compulsory.

Delay is a problem in the payment of third party bodily injury claims. Most insurers want to close third party bodily injury files quickly. Insurers are frustrated by delay. The root cause of delay, aside from congested court lists in some areas,[14] is the lump sum payment compensation system which requires bodily injuries and disabilities to be stabilized before settlement or trial can realistically be considered. The bodily injury delay problem does not have anything to do with the automobile policy, or for that matter, automobile insurers. For years insurers have recognized that delaying resolution of a bodily injury claim works to their disadvantage. Delay is not a problem in the resolution of property damage claims.

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[14] Better case management is recommended by the Ontario Courts Inquiry. This will help.

The O.H.I.P. Agreement

In Ontario, medical and hospital costs of those injured in motor vehicle accidents are for the most part paid by the Ontario Health Insurance Plan (O.H.I.P.). Before December 1, 1978, health care losses caused by motor vehicle accidents were the subject of case-by-case subrogation within the tort system. Each injured plaintiff was required to include O.H.I.P.'s claim in any action commenced against an alleged wrongdoer. Upon recovery of damages, plaintiff's counsel was required to remit O.H.I.P.'s interest to O.H.I.P., less the solicitor and client fee related to processing of the claim. O.H.I.P.'s right of subrogation was contained in section 35 of the Health Insurance Act, 1972.[15]

Case-by-case subrogation was an expensive exercise. O.H.I.P. maintained a large subrogation department to process each claim. Staff was required to assemble, regularly update and forward O.H.I.P. claims data to plaintiff's counsel. Legal advice was needed to assess files resolved by settlement where liability was not clear. Eventually, the inefficiency of case-by-case subrogation was recognized by insurers and the provincial government. Steps were taken to establish a simpler and less costly way of recovering motor vehicle accident-related health care costs. In 1978, the

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[15]R.S.O. 1972, c. 91, (now Health Insurance Act, R.S.O. 1980, c. 197).

provincial government (O.H.I.P.) and most insurers entered into the 1978 Bulk Subrogation Agreement.[16]

O.H.I.P. and most of the automobile insurers in the province agreed that after November 30, 1978, they would abandon case-by-case subrogation and deal with O.H.I.P. claims on a bulk subrogation basis. Under the agreement, a formula based on a percentage of each insurer's third party liability (Section A) premiums was established to indemnify O.H.I.P. for health care costs incurred as a result of motor vehicle accidents.[17]

In 1978, O.H.I.P. estimated that its motor vehicle accident subrogation claims revenue was "... approximately 2% of the gross automobile third party liability premiums payable to the insurer ...". This conclusion provided the basis for the insurers' payment under the Agreement.

It must have been assumed that the amount O.H.I.P. was recovering in case-by-case subrogation provided an appropriate base for calculation purposes. This is questionable, as it is likely that O.H.I.P.'s gross subrogation receipts, before November 30, 1978, fell short of indemnifying O.H.I.P. for motor vehicle-related losses

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[16] The provisions of the agreement have resulted in the insurers now paying 2.4% of "gross premiums". See Appendix XI.

[17] In the 1978 O.H.I.P. Agreement, there is a reference to "gross premiums". However, the agreement defines gross premiums as gross third party liability premiums. The quotation comes from the first recital to the 1978 Bulk Subrogation Agreement.

caused by "... the negligence or other wrongful act or omission of another ...".[18]

The concept of bulk subrogation is sound. The O.H.I.P. agreement has resulted in significant cost savings and it should be continued. O.H.I.P.'s main goal of "...simplifying their administrative procedures and of reducing their administrative costs ..."[19] has been achieved. O.H.I.P.'s subrogation-related administrative costs have been substantially reduced; its subrogation staff has decreased from 67 in 1978 to 16 in 1987. Insurers are no longer exposed to claim-by-claim O.H.I.P.-related transaction costs. The only obvious loser in the deal was that part of the Bar involved in motor vehicle accident litigation. Lawyers acting for plaintiffs regularly billed O.H.I.P. on a percentage basis for collecting O.H.I.P. losses within litigation undertaken on behalf of an injured plaintiff. On occasion, O.H.I.P. was required to retain counsel to exercise its right of subrogation when an injured person did not make a claim. Defence counsel had to deal with O.H.I.P. claims and costs necessarily rose. O.H.I.P.'s claim became part of the settlement negotiation process. Costs paid on settlement were increased, as those costs were usually established as a percentage of the total settlement figure. The presence of O.H.I.P.'s subrogated claim increased the base settlement figure and the cost entitlement of plaintiff's counsel.

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[18]This comes from the first recital in the 1978 Bulk Subrogation Agreement. In many cases, O.H.I.P. settled for less than the full amount of its cost. Other claims were not reported.

[19]O.H.I.P. Agreement, p. 2, Appendix XI.

Not all automobile insurers licensed to carry on business in Ontario are signatories to the 1978 O.H.I.P. agreement. All non-signatory insurers are small companies. When non-signatory insurers are involved, O.H.I.P.'s claims are dealt with on a claim-by-claim basis. There are no data available from which to estimate what O.H.I.P. is losing by the non-reporting of claims in which it has an interest and the defendant is insured by a company outside the agreement. It is probable that some losses are occurring. O.H.I.P.-related transaction costs are increased by this continuing need for some case-by-case subrogation.

Some insureds have established special arrangements with their automobile insurer that inevitably result in O.H.I.P. being shortchanged under the 1978 Agreement. Several large companies prefer to be virtual self-insurers.[20] I have not examined those arrangements in detail. It is clear that a number of large companies comply with the Compulsory Automobile Insurance Act by obtaining the required automobile insurance policy coverage (often with minimum limits).[21] The policy obtained is a fronting policy only. The insured and the insurer enter into a collateral agreement, often by endorsement, whereby the parties agree to a large third

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[20]The Toronto Transit Commission, Bell Canada, Canadian National and Canadian Pacific Rail are, or have been, good examples of companies which have entered into some kind of special arrangement with an automobile insurer.

[21]R.S.O. 1980, c. 83.

party deductible.[22] The arrangement in substance is one of complete self-insurance. The insurer is contractually bound not to pay claims, and is paid an extra premium to process claims for its insured.

There would not be a problem if insureds with special automobile insurance arrangements dealt directly with O.H.I.P., or if an adjustment were made at the insurance company level to ensure appropriate payment in lieu of O.H.I.P.'s original file-by-file subrogation, but this is not happening. If an insurer has entered into an agreement with an insured which has the effect of artificially reducing the gross premium, O.H.I.P. loses money. An example will illustrate how this occurs. In 1980, the Toronto Transit Commission (T.T.C.) was insured with Commercial Union. All T.T.C. vehicles were covered by the policy. The policy provided coverage for $200,000, but endorsements diluted the insurer's obligation to the point where the T.T.C. was essentially a self-insurer. The total premium, for the cosmetic coverage established, was $2,500. Without the special arrangement, the T.T.C. premium would have been closer to $1 million. O.H.I.P.'s entitlement under the Bulk Subrogation Agreement was based on the prevailing 1980 percentage of the $2,500 premium. The T.T.C. obtained the advantage of bulk subrogation at virtually no cost.

Under the Bulk Subrogation Agreement, for the years 1983 to 1986, O.H.I.P. received:

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[22] This results in the insured self-insuring losses up to the deductible.

1983	$21,188,321.88
1984	$22,374,074.00
1985	$24,764,344.00
1986	$29,052,277.00

O.H.I.P. still subrogates on a case-by-case basis where motor vehicle claims involve underinsured claims (SEF 42 or SEF 44), or uninsured/unidentified motorist coverage (part of Section B of the automobile policy). This requires O.H.I.P. to monitor those claims, particularly when claims for future care costs involve in-hospital future care and, therefore, O.H.I.P.-related future care expense. In underinsured cases, which by definition involve cases where the damages are more than $200,000 (the statutory minimum limit), future care costs are sometimes substantial and involve O.H.I.P. O.H.I.P.'s future care cost interest is both different and separate from other aspects of future care costs, in that O.H.I.P.'s share of the capital sum, established to provide future care cost compensation, need not be, and should not be, grossed-up to take into account the taxation of the income earned on the investment of that capital sum. In some cases, O.H.I.P.'s assessment of the amount it will require for the plaintiff's future care may be different than the opinion of either the injured plaintiff or the defendant.[23] In those cases, O.H.I.P. must retain counsel to place its position before the court.

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[23] For example, in a recent case, O.H.I.P's estimate of a severely injured plaintiff's life expectancy was less than the life expectancy estimate proffered by the expert witnesses for the plaintiff and defendant.

Although I am strongly of the view that the O.H.I.P. Bulk Subrogation Agreement is in the best interest of O.H.I.P., insurers and the public, I have the following recommendations with respect to it:

1. The structure of the Agreement, established almost ten years ago, should be examined to ensure that O.H.I.P., through bulk subrogation, is paid whatever health care costs to which it is entitled as a result of motor vehicle-related accidents, with transaction costs savings being shared by the parties to the agreement on an equitable basis. The Agreement's underlying assumption was that O.H.I.P. was receiving appropriate reimbursement through claim-by-claim subrogation. Its structure has resulted in losses that O.H.I.P. was not recovering in case-by-case subrogation, due, for example, to non-reporting, being forever buried. The question is whether 2.4% of gross premiums, as defined by the 1978 Agreement, is adequate. Should the percentage, or the definition of "gross premiums", be altered? This will require an assessment of what motor vehicle-related health care costs O.H.I.P. is incurring and what part of those costs could be recovered if claim-by-claim subrogation was fully asserted. Care should be taken to avoid expending unnecessary funds on an expensive audit of the 1978 Agreement. Review of the Agreement will at best result in arriving at a reasonable estimate.

2. There is no merit in leaving even small insurers out of the bulk subrogation arrangement. All

insurers should be deemed to be part of the 1978 O.H.I.P. agreement, or any successor agreement. This will bring any new insurers into the contract once they become licensed to sell insurance in this province. Bringing all insurers under the umbrella of the O.H.I.P. Bulk Subrogation Agreement can be done by amendment to the Insurance Act,[24] and as a condition of licensing.

3. Although my mandate does not extend beyond automobile insurance compensation issues, I think that consideration should be given to expanding the concept of the 1978 Agreement to include other claims (e.g., medical malpractice) where O.H.I.P.'s subrogation is on a case-by-case basis. This will work to reduce health care costs in a modest way.

4. Where future care costs are established at trial, or by settlement (whether or not the settlement is structured), O.H.I.P.'s interest, if any, in the future care costs should be identified by the trial judge, or by the settlement documentation. Section 39 of the Health Insurance Act[25] imposes an obligation on trial judges to identify O.H.I.P.'s interest in the judgment "... if the evidence permits...". Trial judges should be reminded of the requirements of section 39 and a similar provision should be added to section 39

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[24] R.S.O. 1980, c. 218.

[25] R.S.O. 1980, c. 197.

requiring settlements in those cases not covered by the 1978 Agreement to identify O.H.I.P.'s interest. The present value of O.H.I.P.'s future care cost interest should be paid to O.H.I.P. The same might be said for expenses incurred by any other government agency if a third party recovery has been effected. All elements of a future care cost settlement or judgment should be specifically identified.

5. A study should be undertaken to determine if the first party underinsured (SEF 44) and unidentified/uninsured coverages should be brought within the O.H.I.P. Agreement so that there would no longer be claim-by-claim subrogation in cases where those coverages are applicable. Premiums levied for underinsured and unidentified/uninsured coverages would have to be considered, but that is not the central issue. The essence of the undertaking is to assess whether money is being wasted on case-by-case subrogation in underinsured and unidentified/ uninsured motorist cases. If it is, and if efficiency can be achieved by expanding the Bulk Subrogation Agreement, that step should be taken. Whether this is done by factoring in a percentage of SEF 44 premiums and the Section B premium attributable to unidentified/uninsured motorist coverage, or by simply adjusting the percentage of the third party liability premium paid by the insurers, is an issue which should be examined by the Ministry of Health and the insurance industry. As matters now stand, the unidentified/uninsured premium is part of the

Section B premium; SEF 44 coverage, although provided by endorsement, results in a premium payment which is required by the Statistical Plan to be recorded with the Section B premium.

6. Any insured and insurer entering into an agreement whereby the issued policy is a fronting policy, or where any endorsement or other agreement results in the insured being a self-insurer, should be required to report the existence of such an arrangement, and its terms, to the Superintendent of Insurance. The insurer and the insured should jointly be required to pay the amount O.H.I.P. would otherwise have received had the special arrangement not been entered into. In the event that O.H.I.P., the insurer and the insured cannot agree, the Superintendent of Insurance should have the authority, after consulting those involved, to deem a premium, if practicable, in order to establish the base for the application of the O.H.I.P. bulk subrogation percentage factor (now 2.4%). Alternatively, O.H.I.P. should have a right of subrogation on a case-by-case basis in those circumstances where the insured is a self-insurer. In that event, some credit would have to be given in recognition of the fact that O.H.I.P. would have received a percentage of the premium reduced by the deductible or fronting policy arrangement. These solutions are imperfect, but they are better than ignoring the problem.

7. Tighter controls should be imposed to ensure that cases which should be processed through the

Workers' Compensation system are not processed through O.H.I.P. Apparently, it is administratively easier to ask an injured worker for his O.H.I.P. number and to short circuit the more cumbersome Workers' Compensation system in that way. This does not result in an increase in costs, but rather a misallocation of costs which should be corrected.

8. Any other government ministries expending funds for those injured by accident should be required to determine and record the cause of the accident. To the extent that the resulting expense is related to motor vehicle accidents, subrogation can then be considered. Subrogation rights are infrequently exercised now in part because no record is kept of the cause of the injured person's disability. Subrogation rights cannot be considered, let alone exercised, if the identification of the nature of the occurrence giving rise to the expenditure is not made. O.H.I.P. is capturing this kind of data; other ministries are not.

(b) Section B (No Fault Benefits)

In 1960, the Select Committee on Automobile Insurance received representations from the All Canada Insurance Association recommending the introduction of no fault benefits in Ontario. In 1961, the Select Committee tabled an interim report recommending the inclusion of no fault benefits in the standard form of automobile insurance policy.

Having been recommended by a Select Committee of the Legislature in 1961, in 1969, no fault benefits were introduced as an optional part of the standard automobile policy. In 1972, the existing no fault benefits became compulsory for those who chose to purchase automobile insurance. The 1969-1972 no fault benefits provided non-primary no fault disability benefits of $70 a week maximum. Medical and rehabilitation benefits were $5,000. The no fault death benefit ranged from $500 for the death of a child under five to $5,000 for the death of the head of a household. Five hundred dollars was allowed for funeral and burial costs. A no fault homemaker's benefit, designed to provide financial assistance in cases where housekeeping services had to be replaced, was set at $35 a week maximum.

In 1978, largely in response to the comprehensive report of the Legislature's Select Committee on Company Law, the no fault benefits were increased as follows:

ACCIDENT BENEFITS	COMPULSORY
DEATH BENEFITS:	
- Head of household	$10,000
- Spouse (no age limit)	$10,000
- Dependent child	$ 2,000
- Each dependant beyond first (no limit)	$ 1,000
- Time limit	2 years
FUNERAL EXPENSES	$ 1,000
MEDICAL, HOSPITAL, REHABILITATION EXPENSES:	
- Amount	$25,000 excluding O.H.I.P.
- Time limit	4 years
PARTIAL DISABILITY:	
- Income	80% of gross wages to maximum $140 per week
- Time limit	2 years
TOTAL DISABILITY:	
- Income	80% of gross wages to maximum $140 per week
- Time limit	Unlimited
REPLACEMENT SERVICES:	
- Homemaker benefits	$70 per week
- Time limit	12 weeks

Ontario's no fault, Section B coverage has not been changed since 1978. The view that the no fault benefits should be increased is almost unanimously held.[26]

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[26]A very small number of those making submissions to this Inquiry suggested enriched disability income benefits would provide a disincentive for an injured person to return to work. This concern relates only to the suggested increase in the maximum $140 per week disability benefit.

The no fault disability benefits coverage contained in Section B of the standard form of automobile insurance policy is not primary; collateral source payments are either deducted or prorated. The following example of the treatment of collateral source payments in the calculation of an insured's entitlement to disability benefits illustrates how some typical collateral source payments are deducted and others prorated:

EXAMPLE

The injured person earns $300 a week and receives the following payments after the accident:

(a) $125 a week through his or her contract of employment;

(b) $75 a week through U.I.C. Sickness (Accident) coverage;

(c) $180 a week under a private sickness and accident policy;

(d) $125 a week from an automobile club insurance scheme.

(Total collateral source payments: $505 a week.)

There is no collateral source deduction in the first two weeks. The injured person referred to above will receive $140 a week for the first two weeks of disability. After the first two weeks of disability, collateral source payments are taken into account; the calculation of the insured's disability benefit entitlement is as follows:

(a) Take 80% of the insured's gross wage of $300 a week ($240).

(b) Deduct the U.I.C. benefit ($75) and what the insured received under his contract of employment ($125).

Total deduction: $200.

Income loss for disability benefit calculation is $40 ($240-$200).

The $40 base income loss results from the direct deduction of the U.I.C. and contract of employment collateral source payments. The injured person's payments under the two privately-arranged coverages (the sickness and accident policy and the automobile club policy) are not deducted. These payments are prorated once the base income loss calculation ($40) has been established:

$$\frac{\text{Gross wages - (U.I.C. + Employment benefits)}}{\text{Income Loss + (private sickness and accident benefits + auto club benefit)}} \times 40$$

OR

$$\frac{300-(75+125)}{40+(180+125)} \times 40 = \$11.59$$

In the above example, the injured person would be entitled to a Section B disability benefit payment of $11.59. After the first two weeks of disability, he or she would receive $516.59 while disabled, subject to income tax deductions from the receipt of U.I.C. benefits and group insurance benefits from employment.

To be eligible for disability benefits, the insured must have been employed or be deemed to be employed. To be deemed to be employed, the insured must be 18 or over and under 65 and must have worked six months out of the previous twelve.

There are two standards of disability. For the first 104 weeks, the injured person must suffer "...substantial inability to perform the essential duties of his occupation or employment ...". After 104 weeks, a different standard of disability applies. To be eligible for further disability benefits, the insured must establish that "...such injury continuously prevents such person from engaging in any occupation or employment for which he is reasonably suited by education, training or experience ...".[27] The insured who passes this test is entitled to disability benefits for life if he or she remains totally disabled in accordance with the above definition of total disability.

The no fault section of the standard form of automobile insurance policy also provides a homemaker's benefit of $70 a week for 12 weeks. This benefit is payable only if the homemaker, male or female, is unpaid, resides in the household, is not engaged in employment for wages or profit and is "completely incapacitated and unable to perform any of his or her household duties." The homemaker need not be related to the insured.

The medical, hospital and rehabilitation benefit is limited by time and amount. The expense must have been incurred within four years of the accident and is limited to $25,000. In practical terms, O.H.I.P. absorbs all medical and hospital expenses and all in-hospital rehabilitation expenses. O.H.I.P. also pays for any

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[27]The disability standards are referred to in the standard form of automobile insurance policy Section B and s. 233(1).

in-hospital dental care. The medical/rehabilitation part of the Section B no fault package requires the insurer to pay "reasonable expenses incurred" within four years of the accident. The expenses covered by the policy provision are expenses "...essential for the treatment or rehabilitation of such person ...". Chiropractic and dental expenses are included, as is coverage for occupational retraining, often done through government or community agencies, at no cost to the insurer. Ontario courts have held that the cost of transportation to receive medical treatment, if both necessary and reasonable, is recoverable under this part of the Section B coverage.[28]

Death benefits are payable only if death occurs within 180 days of the accident, or within 104 weeks if the insured was continuously disabled throughout the period. The amount of the death benefit depends upon the status of the deceased and eligible beneficiaries at the time of the accident. If the deceased is the head of the household, or the spouse of the head of the household, the death benefit is $10,000. If there is one dependant other than the surviving head of the household or spouse of the head of the household, that dependant receives $2,000. If there are other dependants beyond the first, those dependants are entitled to $1,000, but only in the event that the deceased is the head of the household.[29]

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[28] Carroll v. Citadel General Assurance Co., [1983] I.L.R. 1-640 (Ontario Div. Ct.).

[29] For a consideration of issues relating to the meaning of head of the household, the spouse of the head of the household, spouse, dependant and household, see J. Newcombe, The Standard Automobile Policy Annotated (Toronto: Butterworths, 1986).

EXAMPLE

If the deceased is head of the household, and if the claimants include a spouse, two dependent children and a dependent mother-in-law, the following death benefits would be paid:

(a) $10,000 to the spouse of the deceased head of the household;

(b) $3,000 to the two children and the mother-in-law (three dependants);

(c) $1,000 funeral.

Total: $14,000 paid to the spouse of the head of the household.

Problem Areas

(i) Rehabilitation

There is a problem with both the looseness of the definition of rehabilitation and its interpretation. The result is that many contractually entitled to rehabilitation are not receiving it.

Rehabilitation, as covered in Section B of the policy, relates, in practical terms, to out-of-hospital rehabilitation and, in my view, is intended to cover vocational and physical rehabilitation. O.H.I.P. looks after in-hospital medical and rehabilitation-related expenses. O.H.I.P. coverage is universal. The provisions of Section B make medical rehabilitation benefits secondary to any other available benefits. Generally speaking, there are no problems with medical and health care expenses. Out-of-hospital rehabilitation, however, is another matter.

Subsection (1) of Section B deals with rehabilitation in such a way as to require that the insured incur a rehabilitation expense before the insurer is required to make payment. While some recent cases suggest otherwise,[30] insurers generally have viewed the contractual obligation to pay first party rehabilitation benefits as an obligation which crystalizes only upon the rehabilitation expense having been incurred. This is destabilizing. It results in delayed or no rehabilitation. Many injured persons understandably want to know if their insurer will pay rehabilitation expenses before the expense has been incurred. Moreover, rehabilitators have more than a passing interest in whether they will be paid for their work.

All submissions relating to rehabilitation suggested that rehabilitation must be undertaken at an optimum time (usually early) to be most effective. The system has not properly responded to the rehabilitation needs of those injured in motor vehicle accidents who reasonably require out-of-hospital rehabilitation. Some rehabilitators rhetorically refer to the no fault rehabilitation benefit as the no-pay rehabilitation benefit.

The existing rehabilitation benefit is badly structured in another area. The insurer's "medical advisor" seems to have a veto power over proposed rehabilitation; in the absence of agreement, the insurer's medical advisor must be brought into the rehabilitation debate before rehabilitation is undertaken. The insured

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[30] See for example Macdonald v. Travelers Indemnity Co. of Canada (1987), 60 O.R. (2d) 385 (H.C.).

can sue; however, this process is slow and costly and as a result mitigates against effective rehabilitation. It seems to me that the emphasis is somewhat misplaced. The injured insured's medical advisor's opinion as to rehabilitation and the opinion of rehabilitation counsellors should be of primary evidentiary significance. The insurer, through its medical advisor, should not have prima facie veto rights. The insurer should be required to absorb the expense of rehabilitation pending resolution of any dispute. From the standpoint of both the insurer and the insured, this will require a more efficient process of resolving no fault disputes. This issue will be discussed in Chapter 13.

Unfortunately, very few insurers recognize the cost effectiveness of rehabilitation. The four-year rehabilitation time limitation contained in Section B seems to have encouraged some insurers to ignore rehabilitation in the hope that its direct costs will simply disappear. Other insurers recognize the potential for cost savings in Section B disability benefits (which may continue for life) if rehabilitation results in the injured insured being able to return to work.

The existence of a tort system claim often means the insured will be represented by a lawyer. Insurers suggest that the end result is that rehabilitation, in some cases, becomes submerged beneath a concern about developing tort system damages. Professor Ison has correctly noted that in any system where there is a tendency for non-pecuniary general damages to increase with time off work, there will

be a disincentive to embark upon a rehabilitation program and, hence, to return to work.[31]

The existing medical rehabilitation benefit is limited by time and amount. The expense must be incurred within four years of the accident and is limited to $25,000. The timeframe unfairly shrinks when there is delay in determining what, if any, rehabilitation program will be undertaken. I.B.C. data suggest that very few cases have involved rehabilitation expense of more than $25,000.[32] That, however, is far from conclusive evidence as to the adequacy of the $25,000 rehabilitation limit.

Head and spinal cord injuries often attract substantial rehabilitation costs. Children with head injuries seem to be the main problem. The rehabilitation process in head injury cases, particularly involving children, may go on for many years. The Ontario Head Injury Association suggests that rehabilitation may continue for as long as 15 to 20 years in some cases.[33] Temporal and quantitative limitations on rehabilitation expense (Section B) should be made less onerous. I

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[31] Terence Ison, "The Therapeutic Significance of Compensation Structures," Can. Bar Rev. 64, no. 4 (1986): 605.

[32] I.B.C. data indicate that the $25,000 four-year limitation is reached in about 30 cases per year or in approximately 0.1% of the cases in which Section B medical payments were made.

[33] In the vast majority of cases involving young children injured in motor vehicle accidents, the injured child has some access to third party tort system compensation. Most injured children are passengers and will have a cause of action against someone.

repeat, however, that the main problem is not the $25,000 four-year limitation, but the availability of the benefit.

It is apparent that better coordination of medical and rehabilitation no fault resources is needed. More, not less, of the disability dollar should go to rehabilitation in those relatively few, but serious cases, in which rehabilitation would be of assistance to the injured person.

The present system lacks an effective dispute resolution mechanism. This comment applies to Section B as a whole, not just to rehabilitation. Too often, rehabilitation proposals made by insureds or their representatives go unanswered. Too often, rehabilitation is delayed while awaiting the consultation and report of the insurer's medical advisor. Too often, the insurer's medical advisor is not equipped by specialty training to deal with rehabilitation-related issues. The net result is that rehabilitation is not undertaken or is undertaken so long after the accident as to limit its effectiveness.

Rehabilitation has been relegated to the position of a footnote in the standard automobile policy. It cannot be allowed to remain there. Changes in the structure of the rehabilitation benefit will be specifically addressed in Chapter 12.

(ii) Disability Benefits

Although the disability benefit is part of the compulsory accident benefits coverage (Section B of the automobile policy), there is no doubt that many who must pay the Section B premium will have little or no need for

Section B's disability benefits. Those who are unemployed or those who have wage-continuation plans will have limited or no entitlement to disability benefits. Except for the "deemed to be employed" as defined in Section B, in order to receive disability benefits, the insured must have a loss of income from employment.[34]

The $140 a week maximum amount was established in 1978 and has not changed since then. The benefit is now less than the minimum wage. Almost all who made submissions to this Inquiry recommended that the $140 a week benefit be increased. Aside from the obvious inadequacy of the benefit which I consider in Chapter 12, the main problem is the delivery of the benefit to those entitled to it. The insurance industry's performance in this area is nothing short of abysmal. I concede at the outset that there are some insurers who do deliver disability benefits reasonably promptly; most do not. Part of the problem lies in the documentation which must be submitted to the insurer. Three forms must be completed. One has to be completed by the insured, one by the insured's doctor and the third by the insured's employer. If there is delay in completing any of these forms, payment of disability benefits is delayed. Once the forms are completed and in the insurer's hands, there is a processing delay on too many occasions. Insurers are not consistent in their requests for medical information. Some insurers seem to require medical reports even in cases where it is obvious that the insured is unable to return to work because of accident-related injuries. When these unreasonable

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[34] The benefit is non-primary.

requests for medical information are advanced, costs rise and delay results.

There are gaps in the definition of those who are entitled to disability benefits. As stated previously, those who lose income from employment, subject to the availability of collateral sources, receive disability benefits. An unemployed insured, unless "deemed to be employed" under the provisions of the policy, is not entitled to disability benefits. To be deemed to be employed, an insured must be 18 or over and under 65 and must have worked six months out of the previous twelve. I question the rationality of excluding 16 and 17-year-olds who are able to drive and work, and who may well qualify under the deemed to be employed provision but for the age 18 restriction.

Students generally are not entitled to disability benefits. Occasional workers are not entitled to accident benefits unless they happen to fall within the policy definition of "deemed to be employed". The temporarily unemployed have no access to disability benefits unless they are deemed to be employed.

A person who is deemed to be employed at the time of an accident is entitled to disability benefits. Disability benefits for the deemed to be employed (as do all disability benefits) commence on day one and are paid for the first two weeks without any collateral source deduction. There is no distinction in substance under the present policy structure between an injured person who has actual employment income and an injured person who does not, but is "deemed to be employed". It strikes me that there is something structurally illogical in treating the

employed and those deemed to be employed similarly. Does it make sense to pay an income replacement benefit from the day of the accident to an injured person who does not have employment and, hence, does not have any employment income to lose, at least in the short term? I think not. On this basis, there should be some waiting or deductible period for the deemed to be employed before payment of income replacement benefits commences. The case for a disability benefit waiting period for the employed is different and will be discussed in Chapter 12. I hasten to add that there is a distinction between an injured person who has a contract of employment, but has not yet started to work, and the deemed to be employed. Upon being injured, the former is treated as having lost employment income for disability benefit purposes as of the date employment would have commenced.

The standard of disability required for disability benefits for the first two years seems to have worked reasonably well. Problems, however, seem to have arisen in dealing with the transition from the disability definition during the first two years to the disability definition from that time on. Insurers are, perhaps, understandably cautious in commencing accident benefit payments after the 104th week. A number of cases have been brought to my attention in which disability benefits were terminated shortly before or at the 104th week, pending the results of examination by the insurer's medical advisor. In one case disability benefit payments stopped in January 1987, approximately two years after the accident, and the insurer's medical examination was scheduled for November 1987. This is hardly a recipe for stability, if that was what was intended by the payment of disability benefits in the first place.

Currently, the certification of disability for disability benefit payment purposes must be provided by a medical doctor. If the insured has been treated by a chiropractor, the necessity of involving a medical doctor for certification but not treatment purposes, causes delay and extra expense. If the insured has sustained a soft tissue injury, for example, and has chosen to be treated by a chiropractor, as long as the insurer has a right to a medical examination, I fail to see why the insured should be forced to go to a medical doctor, not for treatment, but for the singular purpose of having the doctor certify that the insured is unable to work. If the insurer questions a chiropractor's opinion, it has a right to demand a medical examination. This is a sufficient control device.

The 30-day return to work relieving provision contained in Section B of the policy is clearly better than nothing, but is too short. The purpose of this provision was to permit an insured receiving disability benefits to return to work without thereby sacrificing the insured's right to disability benefits in the event that the insured was unable to perform the essential duties of employment. Everyone seems to agree that it is in society's interest, the insurer's interest and the insured's interest that those injured in motor vehicle accidents return to work as soon as is reasonably possible. The 30-day return to work provision provides a disincentive to returning to work. Although some limitation may be desirable for purposes of finality and certainty, the period should be longer than 30 days. The courts have not favoured insurers in interpreting what is

meant by the 30-day return to work clause;[35] nevertheless the wording of the policy in this regard should be made more generous to avoid decisions inconsistent with the purpose of payment of disability benefits and the return to work provision. It should be made clear that return to any employment, not just original employment, comes within the relieving provision; any return to work, including part-time work, should be encouraged, not discouraged.

In addition to there being no expeditious dispute resolution mechanism built into the automobile policy, there is no effective internal or external disciplinary mechanism which would provide insurers with an incentive to extend disability benefit payments to insureds entitled to them without undue delay. Some American jurisdictions have approached this problem through the provision of statutory interest penalties; others have legislation dealing with statutorily-deemed unfair claims practices with monetary penalties.[36] In Ontario, the insured's remedy is to sue. This is an expensive exercise given the fact that in the case of disability benefits, the maximum weekly benefit is $140. In most instances, there is not enough at stake to justify an insured retaining a lawyer to prosecute the insured's claim against the insurer. More effective ways to resolve no fault benefit disputes have to be considered. Aside from the means by which disputes are to be resolved, specific standards have to be

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[35] See Clark v. State Farm, [1982] I.L.R. 945; Matthews v. Co-Operators Insurance, [1985] I.L.R. 7231.

[36] All threshold no fault states (e.g., Michigan, Minnesota, New York and Florida) have some legislation through which penalties are imposed for non- or delayed payment of benefits.

established for both insurers and insureds. Interest penalties such as those used in Michigan, are not sufficient in my view, because of the relatively small sums which are often involved.

(iii) Death and Funeral Benefits

The death benefit is primary. It does not take collateral sources such as life insurance into account. Most concede that the death and funeral benefits are too low.[37] The amount of the death benefit is not directly limited to death-related economic loss. It is difficult to structure a no fault death benefit without considering the basis in principle for the benefit. The I.B.C.'s proposed death benefit, unlike the death benefit in the current policy, is structured so as to be related to the deceased's income.[38] The greater the deceased's income, the greater the benefit. It seems to me a policy decision has to be made as to whether the no fault death benefit should be structured so as to replace pecuniary loss arising from death, or to recognize the value of life in some tangible, yet arbitrary and consistent way. The difficulty with an income-related death benefit is that, particularly if collateral sources such as life insurance are not taken into account, no fault death benefits may be paid to those who will need them least.

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[37] There are those who are of the view that automobile insurance no fault benefits should not contain a death benefit. In general terms, the rationale is that protection for economic loss arising from death should be secured by privately arranged or group life insurance.

[38] See I.B.C. submission, page 11. The maximum death benefit proposed by the I.B.C. is $62,400. For a further discussion of the I.B.C. proposal, see Chapter 12.

If the death benefit is to be structured to replace pecuniary loss, at least in the case of the death of an income earner, it seems to me that to be realistic the death benefit has to be substantially higher than is recommended by the I.B.C. On the other hand, if the death benefit is meant to provide some financial assistance to defined survivors without a policy-based emphasis on pecuniary loss, the death benefit can be more modest.

There is an inconsistency between the Section B definition of spouse for death benefit purposes and the Family Law Act[39] definition of spouse. Consistency in this area is desirable.

It is common ground that the funeral benefit is too low. If a specific benefit is to be paid for funeral and burial expenses, that benefit should bear some reasonable resemblance to the cost of a modest funeral. The $1,000 benefit does not accomplish that goal.

(iv) Exclusions

It is difficult to understand the rationale underlying the Section B no fault exclusions. Section B benefits are advertised as no fault benefits. Yet a conviction for impaired driving works to exclude the insured from medical, rehabilitation, loss of income and, strangely, funeral benefits.[40]

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[39]S.O. 1986, c. 4.

[40]I can concede there will be a somewhat rare case where an insured is in an accident, convicted of impaired driving, and then dies. Defined survivors will be

It seems to me that the no fault benefits contained within the automobile policy should be just that -- no fault benefits. The driving related exclusions should cease to be part of Section B. The policy decision to ignore driver negligence for the purposes of no fault benefits must be premised on the recognition of the need for at least some no fault compensation for death or injury as a result of motor vehicle accidents regardless of driver conduct.

Family members are often affected. It is in society's interest that all injured in automobile accidents be rehabilitated and provided with some stabilizing economic assistance, and that the families of those killed receive reasonable death and funeral benefits. It does not make sense to me to limit no fault coverage by incorporating within it exclusions related to certain criminal offences.

Suicide and attempted suicide are justifiable exclusions as they reflect intentional conduct. The total exclusion referable to an insured ". . . who is entitled to receive the benefits of any workmen's compensation law or plan" is reasonable.[41] This exclusion is reasonable. It serves to internalize cost to the Workers' Compensation regime. To remove this exclusion would run

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entitled to the death benefit but not the funeral benefit. This makes little sense.

[41] See Standard Automobile Policy, Section B: Special Provisions, Definitions and Exclusions, paragraph 2 (II).

counter to the legislative policy underlying the Workers' Compensation Act.[42]

(c) Section C (Loss or Damage to Insured Automobile)

Section C of the standard form of automobile insurance policy requires little comment. This section of the policy provides indemnity against loss or damage to the insured vehicle and its contents. Section C coverage is not compulsory. It is subdivided as follows:

(a) all perils;

(b) collision or upset;

(c) comprehensive;

(d) specified perils.

Collision, with a $100 deductible, and comprehensive coverage, with a deductible ranging in the area of $25-$100, are the most common consumer purchases. As between most insurers, collision losses, like vehicle damage claims under Section A of the policy, are adjusted by resort to a fault chart which is part of the intercompany settlement agreement.[43] The concerns that I expressed earlier about this matter have equal force here.

I heard relatively few complaints about the manner in which collision losses were adjusted. There were a number of consumer complaints about the effect collision losses (accidents) had on premiums. Insureds are generally unaware of the manner in which fault is established

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[42] R.S.O. 1980, c. 539.

[43] See Appendix XV.

through resort to the fault chart.[44] In some instances, premium increases resulting from an at-fault accident appear to the insured as an attempt by the insurer to recover the vehicle damage it has just paid (less deductible). This causes public relations problems, to say the least.

Most of the consumer-related vehicle damage complaints seem to be the product of a lack of awareness that the coverage generally provided is for the depreciated value of the vehicle, not its replacement value. Although there are appraisal and arbitration provisions which may be resorted to in order to resolve disputes as to quantum,[45] most disputes seem to be resolved informally. Those that are not, proceed to litigation, not arbitration.

Repair costs in Ontario compare favourably with those in other provinces. The cost of labour, shop and paint materials is lower in Ontario than in British Columbia, Saskatchewan and Manitoba.[46] Table 5.2 provides a comparison of the cost breakdown in the three western provinces and Ontario:[47]

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[44] This is part of the insurer's intercompany settlement agreement.

[45] Insurance Act, c. 218, s. 207.

[46] Underwriters' Adjustment Bureau, 1986 Provincial estimates.

[47] Mr. G. Potter, Estimate Comptroller, Manitoba Public Insurance Corporation.

TABLE 5.2

BODY SHOP RATES

	Labour	Shop Material	Paint	Total Hrly. Rate
British Columbia				
per hour	$36.65	+ $ 2.41	+ $12.50 =	$51.56
Saskatchewan				
per hour	$33.30	+ $ 3.30	+ $13.35 =	$49.95
(sample repair @ 10 hours = $496.50)				
Manitoba				
per hour	$30.45	+ $ 4.00	+ $14.00 =	$48.85
Ontario				
per hour	$28.00	+ No Allowance	+ $ 5.00 =	$33.00*

*labour cost in Ontario can be as high as $40 although it is often reduced where bidding occurs between larger insurance companies.

As stated in Chapter 7, vehicle damage costs are under control. Nevertheless, all reasonable cost-efficient steps should be taken to establish and control the cost of vehicle repairs. I endorse the use of appraisal centres and would encourage the expansion of those facilities.

Body shop rates are also slightly higher in the Maritimes than in Ontario, partly as a result of the 11% tax imposed on the total estimate for repairs. The rates in Quebec are competitive with those in Ontario. Unlike the Western provinces, Quebec's government automobile insurance corporation allows private insurers to sell coverage for vehicle damage. In Quebec it is mandatory that all vehicles be appraised at approved appraisal shops but the hourly rate is left open and is negotiated by the insurance companies.

Vehicle damage repair costs are positively affected by the competition between "aftermarket parts" and original equipment manufacturer (O.E.M.) parts or "carmaker parts". Aftermarket parts are automobile parts supplied as a replacement for original equipment by a manufacturer other than the carmaker. These manufacturers can be original contract suppliers of O.E.M. parts or other merchandisers. Parts such as tires, batteries, radiator cores, mufflers, spark plugs, oil filters, windshields and others have been accepted as aftermarket parts by consumers for over 50 years. In the early 1970s, aftermarket partial body sheet metal panels became available and in 1983, full body sheet metal panels were introduced. Fenders, hoods, door assemblies, bumpers and grilles are now available as aftermarket parts. The suppliers are manufacturers in Taiwan, Japan, Korea and Brazil, as well as in Canada and the United States.[48]

Automobile insurers spend almost $318 million a year to repair vehicle damage resulting from accidents in Ontario and $6 billion a year in the United States.[49] Insurance companies have encouraged the use of aftermarket parts because of the significant savings involved.

Automobile manufacturers have responded by cutting prices dramatically on auto parts which are also available as aftermarket parts. Where aftermarket parts are

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[48]Letter from Mr. F. C. Fraser, Deputy Regional Vice President, State Farm Insurance Companies, dated July 13, 1987.

[49]Green Book, 1986, p. 291; L. R. Beck, "Carmaker Parts: Consumers Will Pay for Government Support," National Underwriter, (May 25, 1987).

available, competition has reduced prices by 25 to 40%, depending on the type of repair involved.[50] This can be illustrated by comparing the prices of the two-part 1977 Camaro grille. The lower part, which can only be replaced with a monopoly (O.E.M.) part, has doubled in price since 1979 ($24.50 to $51.00). The upper part can be replaced either by an O.E.M. part or an aftermarket part. When a competitive part was introduced at a price of $46.00, the O.E.M. price dropped from $90.75 to $51.75.[51] There are numerous similar examples.[52]

Automobile manufacturers have lobbied state insurance officials and the federal government in the United States for regulations which would restrict competition in the auto parts business.[53] They have initiated advertising campaigns to warn consumers about inferior quality in aftermarket parts. They have also publicized the problem of counterfeit and look-alike auto parts, which are said to be substandard parts.

Most aftermarket parts suppliers belong to the Aftermarket Body Parts Association (A.B.P.A.), which has a voluntary certification program. Parts are tested and certified to be of "like kind and quality" as their O.E.M.

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[50] National Association of Independent Insurers (N.A.I.I.), "Competitive Auto Parts vs. Carmakers' Parts," (undated).

[51] N.A.I.I., "Competitive Auto Parts."

[52] One example is a 1986 Mustang front bumper. When unexposed to aftermarket parts competition, the price was $744.20. The O.E.M. when faced with aftermarket parts competition reduced its price to $287.51. The list goes on.

[53] Beck, "Carmakers Parts."

counterparts. Certified parts display distinguishing registered marks and are subject to a written five-year warranty. The A.B.P.A. publishes a directory of certified auto parts.[54]

Body shops may use one or more competitive auto parts suppliers. When a competitive auto part is available, a body shop may choose to include the competitive auto part in the repair estimate. A car owner may accept the body shop recommendation to use competitive parts or may decide instead to use carmaker parts.[55] The consumer is usually not aware of the fact that the replacement part may be an aftermarket part rather than a new O.E.M. part. The estimate shown to the consumer merely reflects the insurer's assessment of the loss.

All insurance companies should be required to establish quality and service guidelines for the use of aftermarket parts. Parts should be of O.E.M. quality and the quality should be guaranteed by both the supplier and the insurer. The use of aftermarket parts where available is to be encouraged in the interest of controlling vehicle damage repair costs. Consumers should be informed of the name of the manufacturer of the auto part being used in the repair; this would promote consumer recognition of quality brands and discourage the use of uncertified parts. There should be severe penalties for

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[54] Statement of the Alliance of American Insurers on the National Association of Insurance Commissioners' Aftermarket Parts Model Regulation. (Undated)

[55] N.A.I.I., "Competitive Auto Parts."

the importation or sale of substandard, counterfeit or look-alike auto parts.

(d) Uninsured/Unidentified Motorist Coverage

Since March 1980, the no fault section of the automobile policy has included Ontario's compulsory uninsured motorist coverage.[56] That coverage is in Section B but can best be considered separately. Uninsured coverage was included in the automobile policy with the advent of the Compulsory Automobile Insurance Act[57] to provide compensation for bodily injury or death caused by an unidentified or uninsured automobile.

Damage to the insured vehicle and its contents is included in the uninsured motorist coverage. The coverage is not no fault; the insured must establish fault on the part of the uninsured or unidentified motorist in order to secure compensation.

The total coverage provided is the existing minimum third party liability limits in the jurisdiction where the accident occurs, regardless of the number injured or killed. This becomes significant in United States jurisdictions having low minimum limits. The maximum recovery by an Ontario insured injured in the United States by an uninsured or unidentified motorist will

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[56] Insurance Act, R.S.O. 1980, c. 218, s. 231. This coverage is compulsory; uninsured coverage is not. Underinsured coverage is provided by endorsement (now SEF 44).

[57] R.S.O. 1980, c. 83.

invariably be substantially lower than in Ontario as no American state has minimum limits as high as $200,000.

Vehicle and contents damage claims are subject to a $100 deductible and a property damage limit of $25,000. Bodily injury claims have priority up to $190,000 (in Ontario). The priority is expressed in percentage terms (95% bodily injury priority).

The uninsured (or unidentified) motorist is responsible for any sum paid by the insurer under the uninsured motorist coverage. If there is a judgment, the judgment is assigned to the insurer before payment. If the claim is settled, the insurer is subrogated to the rights of the person to whom payment was made.[58] Accident benefit payments do not reduce the uninsured motorist's liability. Although uninsured motorist coverage is part of Section B of the policy, the special provisions, definitions and exclusions of Section B are not applicable to the uninsured motorist coverage. The automobile policy's general provisions, definitions, exclusions and statutory conditions do apply. Uninsured/unidentified motorist coverage does not belong in Section B of the policy. I will deal further with that issue when making recommendations as to policy structure.

(e) Underinsured Motorist Coverage

Underinsured coverage first became available in August 1980. This coverage is not compulsory, but is purchased by approximately 90% of insured drivers. Brokers are

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[58] Insurance Act, c. 213, s. 23(5).

reluctant not to provide this coverage; therefore it is sold with the compulsory automobile insurance package (Sections A and B) unless the insured specifically declines to purchase underinsured protection. The underinsured endorsement is now known as SEF 44, the Family Protection Endorsement. The SEF 44 endorsement replaced SEF 42. SEF 44 underinsurance protection applies to policies containing that protection written after February 1, 1985. The SEF 42 endorsement still applies to relevant policies written (and accidents occurring) before February 1, 1985.[59]

Underinsured motorist coverage is designed to provide first party protection when the insured suffers loss or damage because of the negligence of a defendant who has insufficient insurance coverage. The purpose of both the SEF 42 and SEF 44 endorsements is to put the injured person in essentially the same position he would have occupied had the negligent driver's limits been equal to the insured's own Section A third party limits.

The first party insurer's SEF 44 accident exposure does not vary with the number of claimants, injuries, deaths or vehicles involved. SEF 44 represents the

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[59] For a detailed discussion of SEF 42 and its implications in multiple claimant accidents, see Borland v. Muttersbach (1985), 49 O.R. (2d) 165. See also J. R. Morse, "S.E.F. No. 44 Underinsured Motorist Coverage," Advocates' Qtly. 7(1986-87):185; P. M. Iacono, Underinsured and Uninsured Motorist Coverage, Paper prepared for Canadian Management of Professional Development (October, 1985); and R. M. Bogorach, Uninsured and Underinsured Coverage, Paper prepared for the Department of Continuing Education, Canadian Bar Association (May 23, 1987).

difference between the insured's Section A policy limits (or, in rare cases, some other amount that is specified as applying to the SEF 44 endorsement), and the total of all limits of motor vehicle liability insurance of the inadequately insured motorist and any person who may be jointly liable.

SEF 44 coverage is different from that provided by SEF 42 in these general respects:

(a) F.L.A. derivative claimants are insured persons under SEF 44; there was some doubt about this under SEF 42;

(b) SEF 44 coverage has been limited to named insured persons, their spouses and dependent family members in the same dwelling premises subject to the exception that infirm children over the age of 18 and dependent upon the named insured or children attending school, college or university are specifically included within the meaning of named insured;

(c) there is clearly no underinsured coverage under SEF 44 for damage caused by an unidentified motorist;[60]

(d) the SEF 44 coverage is excess to amounts recovered pursuant to policies providing disability benefits, loss of income benefits, medical benefits or rehabilitation benefits.

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[60] Compare SEF 42. See Wigle v. Allstate (1985), 49 O.R.(2d) 101 (C.A.).

This eliminates overcompensation permitted at common law;[61]

(e) under SEF 44 prejudgment interest is only payable after the first party insurer has received notice as required by the endorsement;

(f) the underinsurer has a right to contest the main action under SEF 44;

(g) although it remains to be seen how the courts will interpret the limit of the coverage extended by SEF 44, it would appear that the underinsured coverage is limited to the difference between the Section A limits of the not at-fault motorist and the Section A limits of the underinsured motorist;

(h) passengers in vehicles with SEF 44 coverage do not benefit from the coverage. Passengers are covered for underinsurance if they have an SEF 44 policy under which they are a named insured or a dependent relative of the named insured.

C. GENERAL RECOMMENDATIONS AS TO THE STANDARD FORM OF AUTOMOBILE INSURANCE POLICY

I have now discussed the various coverages and delivery problems under the standard automobile insurance policy. I began this chapter by saying that the policy taken as a whole was badly structured and incomprehensible. The following are some general recommendations:

1. A committee should be established to redraft the standard automobile insurance policy once

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[61] Boarelli v. Flannigan, [1973] 3 O.R. 69.

decisions have been made as to policy structure. Drafting should not be left solely to lawyers (or judges) or committees of the insurance industry. Those responsible for redrafting the policy should start from the premise that it is not an act of generosity, but of necessity that lay persons be able to understand the policy. We can usefully look to American experience. In Montana, a drafting committee established by the State included a lay person (a journalist) who was given a veto power on matters of form. Arizona, Florida and Pennsylvania have included communications experts for drafting purposes.[62] Legal advice will, no doubt, be required.

2. The policy structure should be reconsidered. I think most people are confused by the casual use of words such as part, section and subsection. The dominant divisions in the policy are the sections, next come the subsections and then the parts. That seems to me to be doing it backwards; it should be the other way around.

3. The general definitions and provisions should be those which apply to the entire policy, without exception. Definitions and provisions which apply to particular parts of the policy should be in the relevant part of the policy.

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[62] The Committees to which I refer were responsible for redrafting jury instructions, not insurance policies. Assuming both jury instructions and insurance policies should be understandable, the American experience is worth looking at.

4. Exclusions relevant to each part of the policy should be contained in that part so that there is a clear understanding as to what coverage is excluded.

5. The uninsured/unidentified motorist coverage should be taken out of Section B and put in a separate part of the policy. The Quebec accident provisions should not be included in Section B.

6. The policy should be structured as follows:

Part 1: Third Party Liability

Part 2: No fault Benefits:

(i) medical and rehabilitation benefits
(ii) disability benefits
(iii) death and funeral benefits
(iv) other benefits

Part 3: Vehicle Damage:

(i) collision
(ii) comprehensive
(iii) specified perils
(iv) all perils

Part 4: Uninsured/Unidentified Motorist Coverage

Part 5: Supplementary Benefits respecting Accidents Occurring in Quebec

Part 6: Statutory Conditions, Policy Provisions and Definitions

(i) Statutory Conditions
(ii) General Provisions and Definitions

Part 7: Endorsement Coverage including SEF 44.

CHAPTER 6

INSURANCE PRINCIPLES, THE CLASSIFICATION SYSTEM AND UNDERWRITING

A. INTRODUCTION

If I have learned nothing else during the course of this Inquiry, it is that insurance is a complex business into which non-experts should tread with extreme caution. In this chapter, I propose to consider basic insurance principles, as related to automobile insurance; how premiums are established through the classification system; the underwriting process; and special cases of difficulty (taxis, young drivers, motorcycles, off-road vehicles and trucks).

I should make it clear that I do not consider it either within my competence or terms of reference to design an automobile insurance classification system, or a system of regulating automobile insurance in Ontario. I do intend to proffer recommendations as to the criteria against which a classification system should be evaluated and the need, or otherwise, for regulation of automobile insurance premiums generally. Rate regulation will be considered in Chapter 16.

At least from the standpoint of automobile insurance, the public's concern is about premiums. The public debate in this area consistently raises the issues of fairness and affordability. A number of questions are repeatedly asked. Why should A and B, both with no motor vehicle accident experience, be required to pay different automobile insurance premiums? Why should the driver in

Vancouver pay less for automobile insurance than his twin brother in Toronto? Why should the driver in Kenora pay more for automobile insurance than a similar driver in Dauphin, Manitoba? Why should drivers in Toronto pay more for automobile insurance than drivers in Kenora, or Ottawa for that matter? Then, there are ethical questions of whether it is right that young drivers pay higher premiums than older drivers; that women pay lower premiums than men; that the unmarried pay higher premiums than the married. These are questions and issues which deserve to be dealt with. An understanding of the general principles of insurance is required, if not by all, at least by those who claim to represent those affected by allegedly high and unfairly allocated insurance premiums.

B. GENERAL INSURANCE PRINCIPLES AND RISK CLASSIFICATION

Insurance is a mechanism by which an individual exchanges the risk of an uncertain and potentially large loss for a certain, but smaller loss.[1] Another way of putting it, in the automobile context, is that automobile insurance is a means for providing for the uncertainty associated with automobile accidents. The uncertainty of the event (a motor vehicle accident), the timing of the event and its severity are uncertainties (risks) assumed by the insurer for a predetermined price (premium).[2]

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[1] N. Shayer, Driver Classification and Automobile Insurance," in Automobile Insurance Risk Classifications: Equity and Accuracy/Massachusetts Dept. of Insurance, 1978.

[2] A somewhat similar definition of insurance can be found in Risk Classification - A Statement of Principles by the Canadian Institute of Actuaries.

The insurance contract is concluded by the payment of a premium and its acceptance by the insurer. In general terms, premiums paid by the many go to pay the motor vehicle accident losses of the few. Through insurance, losses are distributed. Although there are a large number of motor vehicle accidents, particularly accidents involving property damage, there are, nevertheless, relatively few such occurrences in relation to the number of people who pay automobile insurance premiums.

Premiums paid by an insured should reasonably reflect the degree of risk the insured imposes on the system. This raises the question of how a given risk is to be assessed. One way is to rely on intuition and, one might hope, good judgment. Another obvious method is to take into account the risk's actual loss experience and driving record over an extended period. Both methods are unreliable and unworkable. Undertaking a risk by intuition is obviously suspect. Too many variable judgment calls from too many people are required. Quality control is deficient. Considering a given risk's actual loss experience and driving record on its own is unworkable. There may be no data available (for example in the case of a newly licensed driver). Data that are available will often be short-term. Data provided may be inaccurate and need costly verification. Moreover, information obtained by taking account of the past may have no relevance to present or to future expected risk exposure.

Because individual risk assessment is manifestly unworkable, risks have to be grouped for premium rating purposes. The Canadian Institute of Actuaries put the principle this way:

> That the grouping of risks with similar risk characteristics for the purposes of setting prices is a fundamental precept of any workable private voluntary insurance system.[3]

The grouping of insureds with similar risk characteristics is done systematically, not randomly. The structure established is referred to as the classification system. This system represents the grouping structure within the automobile insurance system. The purpose of the exercise is not to identify unusually good or bad risks, or to reward or penalize certain groups at the expense of others. The purpose is to group individual risks with similar loss expectations. Insureds are allocated to predetermined cells. An individual within a group or cell represents no more predictable a risk than that individual was before allocation to the cell. By allocating insureds to groups with similar risk characteristics, a reasonable price can be established by observing the groups' losses and relating the price to the average experience of the class. In a competitive environment there is an incentive to refine classifications to more accurately reflect expected loss costs among identifiable classes of risk. Because classification is fundamental to insurance, the question is not about whether to draw lines so as to establish

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[3] Canadian Institute of Actuaries, Risk Classification - A Statement of Principles.

cells or groups, but rather where those lines will be drawn.

The creation and continuation of any classification system is dependent upon statistical data. Statistical data were first gathered in a formal way by the Canadian Automobile Underwriters Association in 1926. A statistical plan was devised by the Canadian Automobile Underwriters' actuary at that time. In 1929, an Ontario Royal Commission on Automobile Premium Rates was established. In 1930, the Commissioner, Mr. Justice Hodgins, recommended in his Report:

> That the loss costs of insurance in Ontario in the future should be established by the combination of the experience of all companies, and that such experience should be developed on the statistical plan prescribed pursuant to Section 69(A) of the present Insurance Act.

The Hodgins Report led, at least indirectly, to statutorily required statistical reporting by the insurance industry. Since January 1968, the I.B.C. has been the government's statistical agent. In provinces other than Quebec, British Columbia, Saskatchewan and Manitoba, rates are established from the collective loss experience compiled within the framework of a government approved statistical plan. The statistical plan has been revised from time to time since it came into force in 1930. Changes are subject to approval by the relevant provincial Superintendents of Insurance.

Insurers compile and collate statistics by class. Insurers are not required to use specific methods of recording statistics. Statistical data submitted by automobile insurers are collected by the Statistics

Division of the I.B.C. The collated statistics are assembled in what is commonly called the "Green Book" which contains data required to be collected by the statistical plan and other information thought to be important to insurers. The Insurers' Advisory Organization (I.A.O.) also collects data, which includes the results of I.A.O. members' and some individual companies' loss experience. Although all companies must report required information further to the statistical plan, not all companies have access to I.A.O. recommended premium rates, nor do all insurers establish rates on the basis of the I.B.C.'s Green Book data. Larger companies do not have to resort to that data. Smaller companies do not have a sufficiently large data base and are compelled to seek access to Green Book data, and perhaps I.A.O. data and recommended rates.

There is no doubt that adherence to the statistical plan tends to perpetuate business practice. The submission of one insurer to this Inquiry referred to the statistical plan as encouraging "lemming-like behaviour" within the automobile insurance industry. This concern gives rise to the "cart-horse" question of whether business practice determines what statistics are gathered or whether statistics obtained determine business practice. A Board of Inquiry appointed under the Ontario Human Rights Code hearing a case in which age classification was challenged, put it this way:

> To what extent are we using statistics to justify business practice or to what extent are business practices flowing from statistical analysis?[4]

Ontario's classification system has become increasingly complex. In the 1940s there were two classes: business and pleasure. In 1950-51, age was introduced as a rating factor and four classes were established. The four classes were:

(a) pleasure - no driver under 25;

(b) pleasure - principal driver under 25 - business or pleasure;

(c) all other pleasure use (including occasional use by a driver under 25); and

(d) all other business use.

In 1957, the classification system was expanded to five classes. For the first time a distinction as to sex was made part of the classification system. In 1961, the classification system expanded to include seven classes. Mileage was introduced at this time. A distinction was made between those driving under 10,000 miles a year and those driving over 10,000 miles a year for pleasure or business. In 1964, marital status became a rating variable for male drivers under 25. This resulted in the number of cells within the classification system increasing to nine. By 1968, the number of classifications had increased to 14 as a result of

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[4] Bates v. Zurich Insurance Company, Frederick Zemans, Chairman [1985] I.L.R.I.-1942.

establishing sub-groups of male and female drivers under 25.

There is also a territorial aspect to risk classification. The province is divided into 12 regions for purposes of the classification system. The I.B.C. collects data in 19 statistical areas. Loss experience has confirmed that loss costs are higher in Toronto than in Kenora. Traffic density is the main factor. There is a direct relationship between traffic density and accident frequency. In simplistic terms, that is why insurance is cheaper in Kenora than in Toronto and why, for example, drivers in Victoria pay lower premiums than drivers in Vancouver.[5]

Recent challenges to the classification system have not been related to the concept of classification, but rather its application. The specific focus of attack has been on the legitimacy of establishing cells based upon an insured's age, sex or marital status. There have been other criticisms of the classification system; however, the issues of age, sex and marital status seem to dominate.

There are those who believe that certain risks, such as newly licensed drivers, are good risks until those drivers prove otherwise. Those espousing that view almost always mean well. The "good-until-proven-otherwise" approach to premium rating seeks validation in the principle of fairness. That altruistic approach to

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[5] British Columbia also uses territorial rating, although it resorts to relatively fewer rating territories.

premium rating is fundamentally flawed. Rating judgments have to be made before, not after the event. Accident-free drivers in any workable insurance system will always pay something for the sins of the negligent drivers within the system. That is what insurance is all about.

Professors Rea and Trebilcock in their paper Rate Determination in the Automobile Insurance Industry in Ontario, 1982, put it this way:

> The notion that "clean risks" pay for bad risks when drivers are included in high-risk categories but turn out subsequently to be accident free, really involves the misconception that fairness should be judged not when the risk is presented to the insured, but ex post facto, when some drivers are known to be loss free. Following this line of reasoning, someone who bought term life insurance, but did not die during the period of coverage might argue that, ex post facto, got nothing for his money. The classification system should be judged ex ante when risks are being assessed, not ex post.[6]

The basic principle that expected future, not past, loss costs must be assessed is often forgotten or ignored. In setting premiums the objective is to fairly and objectively identify and group similarly situated risks, to determine average expected loss costs and then to apply those average costs to all members of the group. This does not mean that past losses and those who caused them are not to be taken into account in determining premiums. Past at-fault accident involvement will typically result in a premium increase because it is thought to be predictive of future at-fault involvement, not because the

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[6] Rea and Trebilcock, Rate Determination, p. 46.

insurer is attempting to get his money back. In a competitive industry such as exists in Ontario no individual insurer can seek to recoup its past losses; it must price its policies to reflect expected future losses.

Once groups or cells are established by a classification system, even if the system is sound in principle, there may still be arguments advanced that a certain group's premiums are excessively burdensome. Any response to this argument must be a social policy response. If a particular group's reduction in premiums is not statistically justified, other drivers will pay the price. This is cross-subsidization. Those who seek statistically unjustified premium reductions for a particular group are often motivated by a sense of fairness. This may legitimately be viewed as unfair by motorists called upon to subsidize those drivers whose premiums have been set below a statistically justified level.

Cross-subsidization of a particular group or cell by others within the system runs counter to the competitive dynamics of the private sector delivery of insurance.[7] When any subsidization exists or is perceived to exist, certain risks will be, or will be seen to be, over and underpriced. Competing insurers will avoid writing underpriced risks and attempt to secure business that is overpriced. Risks that are avoided will eventually add to the population of the Facility Association.

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[7] The issue of cross-subsidization is also discussed in Chapter 15.

C. CLASSIFICATION SYSTEM EVALUATION

Any classification system must be measured against a number of efficiency and equity criteria. The following are among those criteria which I regard as being significant:

(a) Homogeneity

This refers to the need for the expected loss costs of members of a cell, established through the classification structure, to be reasonably similar. It is the expected losses by which homogeneity is measured. Professors Rea and Trebilcock put it this way:

> The expected loss of each individual group member should ideally fall as close as possible to the mean expected loss of the class as a whole.[8]

Not all risks in a class will have the same claims experience. No one can reliably predict individual claims experience. Similarly, the fact that the claims experience of an insured in one cell is the same as the claims experience of an insured in another cell is to be expected and does not mean the classification system is badly constructed, or that a given insured has been placed in the wrong cell within the system.

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[8] Rea and Trebilcock, Rate Determination.

(b) Separation

Just as individual members of a class should have similar expected losses, the class as a whole should demonstrate a difference in expected losses when compared with any other class. Overlapping, in other words, is to be avoided.

(c) Reliability

The classification system must be structured so that individual expected losses can be predicted. To attain this goal individual cells must be easy to administer and relatively immune to fraud and administrative error. This criterion requires that the rating factors be susceptible to accurate and cost-efficient verification.

(d) Acceptability

While not determinative, rating variables and the resulting cells within a classification system must be socially acceptable. This criterion is often referred to as admissibility. For example, premium rating based on race or religion is clearly unacceptable, even if one could successfully argue there is some statistical validity to their use. This criterion is at the root of the attack on age, sex and marital status as rating variables.

(e) Incentive value

A soundly structured classification system will make efficient use of incentives that will encourage policyholders to take precautions. This will reduce losses. Rating variables within a classification system about which the policyholder can do nothing (e.g., sex) do not accomplish that goal.

The five criteria referred to above reasonably dominate the evaluation of any classification system. I note that there are other evaluation criteria which are used.[9]

The classification codes in the current classification system break down this way:

THE PRESENT PRIVATE PASSENGER AUTOMOBILE CLASSIFICATION
(First two positions of class, driving record code)

PLEASURE - NO DRIVERS UNDER 25 except as noted

Class 01: No driving to work; annual mileage of 10,000 or less; two or less operators per automobile who have held valid operators' licences for at least the past three years. Married female occasional operators under 25 may drive and unmarried female occasional operators under 25 with driver training may drive.

Class 02: Driving to work ten miles or less one way permitted; two or less operators per automobile. Married female occasional operators under 25 may drive and unmarried

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[9] See Canadian Institute of Actuaries, Risk Classification; Rea and Trebilcock, Rate Determination. Others include credibility, predictive stability, expense, constancy, causality and controllability.

female occasional operators under 25 with driver training may drive.

Class 03: Drive to work over ten miles permitted; female occasional operators under 25 may drive.

PLEASURE OR BUSINESS

Class 06: Occasional male operator use--male under 25. (Note--the principal operator insures the automobile for use by all other drivers under Classes 01, 02, 03 or 07.)

Class 07: Business primarily; no male operators under age 25.

PRINCIPAL OPERATORS UNDER 25 YEARS OF AGE

MARRIED MALE: (residing with spouse)

Class 08: Ages 20 and under
Class 09: Ages 21, 22, 23 or 24

OTHER MALES

Class 10: Ages 18 and under
Class 11: Ages 19 and 20
Class 12: Ages 21 and 22
Class 13: Ages 23 and 24

FEMALES

Class 18: Ages 20 and under
Class 19: Ages 21, 22, 23 or 24

015 driver	-	Class 1	Driving record 5
023 driver	-	Class 2	Driving Record 3
103 driver	-	Class 10	Driving Record 3
183 driver	-	Class 18	Driving Record 3

DRIVING RECORD

5 - rated as five-year clear record
3 - three years' experience without claims
2 - two years' experience without claims
1 - one year's experience without claims
0 - less than one year's experience without claims

D. THE PROPOSED CLASSIFICATION SYSTEM

For a considerable time, the classification system has been under attack. The attack is two-pronged. First, the legitimacy of age, sex and marital status as rating criteria has been challenged; second, the classification system as a whole has been alleged to be too complex.

In light of these concerns, in the spring of 1987, a committee under the auspices of the Ministry of Financial Institutions was struck to establish a new classification system. It is important to note at the outset that the elimination of age, sex and marital status was not something which the committee decided to do on its own. The committee was instructed to proceed to design a new classification system in which age, sex and marital status would not be rating criteria. The legitimacy of age, sex and marital status as rating criteria was not debated. The no age, sex or marital status edict seems to have been ethically based, in the sense that social policy, not actuarial data, determined the issue.

The design of an appropriate classification system is a matter for experts and I do not consider it appropriate to embark upon that undertaking. I will, nonetheless, make some general comments about the principle of risk classification and the proposed classification system.

As has been stated earlier in this chapter, the classification of risks based on expected loss costs is essential to any workable private sector insurance system. If risks are not classified before the event insured against, inevitably those who might reasonably claim to be good risks will pay higher premiums and those who might

reasonably be accused of being bad risks will pay lower premiums.

The classification system developed by the committee established by the Minister of Financial Institutions has proceeded to the second draft stage. The proposed classification system is set out in Appendix XVI. However one might criticize the result, it is apparent that the government and the insurance industry have recognized the need for a classification system. The residual question is not whether we should have a classification system, but whether the one proposed is soundly structured.

Central to the debate about the structure of the proposed classification system is the use (or elimination) of age, sex and marital status as rating variables. The Ontario debate about age, sex and marital status as rating variables has been lengthy, but not profound. In dealing with age, sex and marital status I think it is necessary to consider why those rating variables were used in the first place.

Young drivers are involved in proportionately more accidents, and more severe accidents than other drivers. The data are overwhelming on this issue. The young driver dividing line at age 25 is arbitrary, but supportable. The same comment could be made if the dividing age were 30. Traffic safety experts have generally concluded that young drivers suffer from a lack of general and driving experience and an under-developed sense of risk

perception;[10] young drivers are also said to drive at high risk times.

Sex is used as a rating variable for drivers under 25 because of data which establishes that females are involved in fewer and less severe accidents than males. Being female, or for that matter male, does not in itself cause accidents. There is, however, a statistical correlation which has resulted in sex being a rating criterion. The dominant justification for the use of sex as a rating variable is that it is a reliable proxy for kilometres driven which can be verified at virtually no cost. While verification of sex is both reliable and virtually costless, verification of kilometres driven is relatively unreliable and expensive. In addition to the factor of kilometres driven, if men drive more than women at higher risk times, and as some suggest, with more passengers than women, the expected loss costs of men will be greater than the expected loss costs of women.

Marital status requires little comment. Few tears, actuarial or otherwise, will be shed over its demise as a rating factor. Marital status is another exposure proxy. The underlying assumption is that an insured who is married will drive less than one who is unmarried. The predictive force of marital status is suspect. More importantly, it has become a socially unacceptable rating factor. I endorse the relegation of marital status to history.

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[10] See discussion later in this chapter.

The statistical evidence supporting the use of age as a rating variable is overwhelming. The evidence supporting the use of sex as a rating variable, if not overwhelming, at least supports the conclusion that there is a demonstrable correlation between sex and expected loss costs. This is not a local phenomenon. It applies everywhere cars are driven.

Figure 6.1 illustrates Ontario statistics on the percentage of drivers in each age category who were involved in accidents in 1986. The effect of age on accident rate is obvious. The data for each sex indicate a higher accident rate between ages 16 and 24 than in any age grouping above 24. There is also a marked difference between male and female accident experience. Females have fewer accidents than males at every age level.

Two tables drawing on extensive American data will illustrate why age and sex are used in any classification system.[11] Table 6.1, below, sets out 13 variables which are related to males and females from a base year of age 20 to ages 40 and 65. By way of explanation, the first entry shows 3.73 times as many 20-year-old males are killed in motor vehicle accidents as 40-year-old males. Twenty-year-old males are 55 times as likely to die in a motor vehicle accident as 65-year-old males. Twenty-year-old females are 43 times as likely to die in a motor vehicle accident as 65-year-old females.

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[11] Leonard Evans, "Fatal and Severe Crash Involvement v. Driver Age and Sex," prepared for presentation at the Annual Meeting of the American Association for Automotive Medicine, September 1987.

Figure 6.1

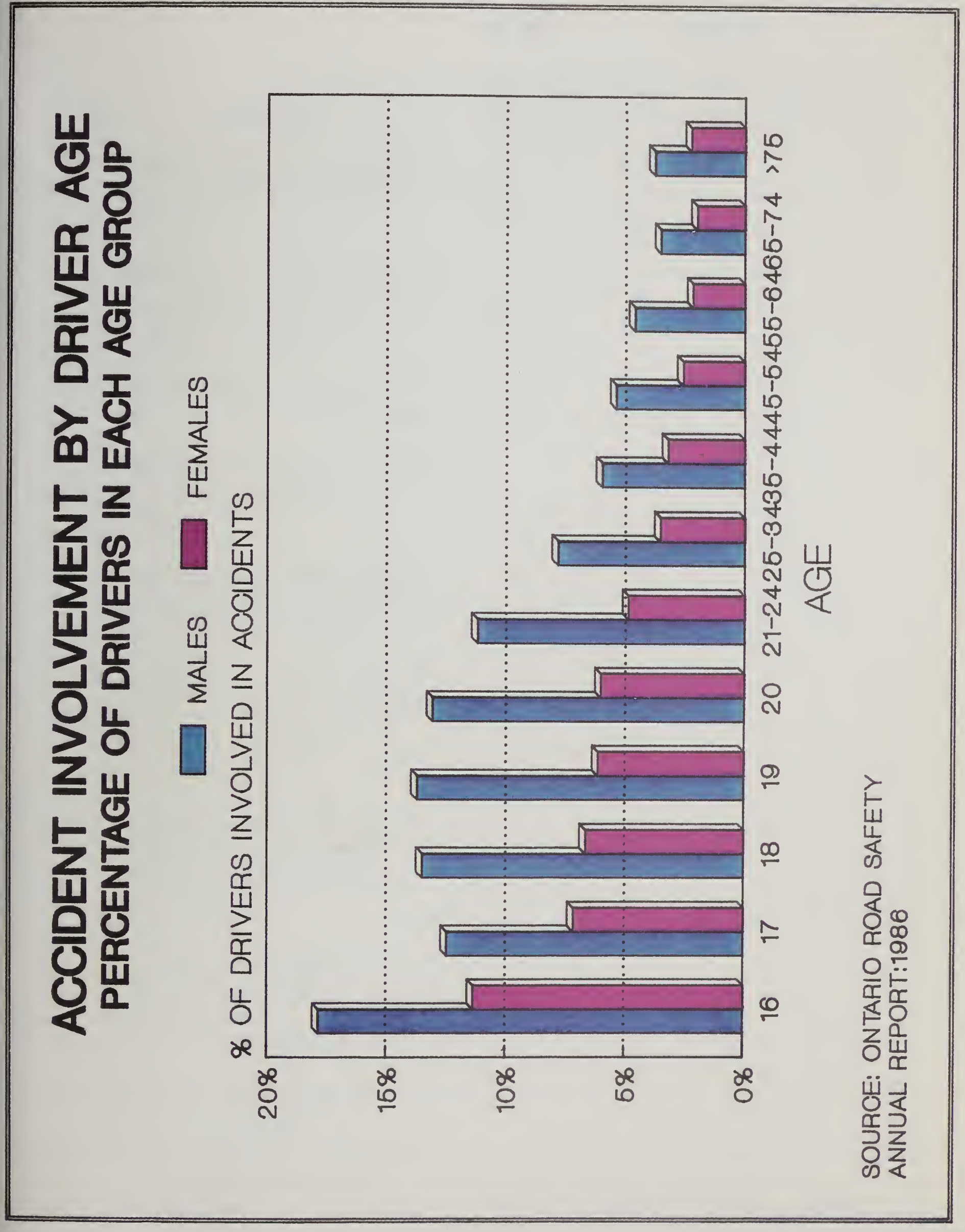

ACCIDENT INVOLVEMENT BY DRIVER AGE
PERCENTAGE OF DRIVERS IN EACH AGE GROUP
MALES
FEMALES
% OF DRIVERS INVOLVED IN ACCIDENTS
20%
15%
10%
5%
0%
16
17
18
19
20
21-24
25-34
35-44
45-54
55-64
65-74
>75
AGE
SOURCE: ONTARIO ROAD SAFETY
ANNUAL REPORT:1986

TABLE 6.1

VARIABLE	MALES		FEMALES	
	Age 20 Age 40	Age 20 Age 65	Age 20 Age 40	Age 20 Age 65
Number of drivers killed (in any type of motor vehicle)	3.73	8.11	2.53	4.48
Number of drivers killed per capita (in any type of motor vehicle)	2.46	3.44	1.75	2.27
Number of drivers killed per licensed driver	2.43	3.22	2.04	1.94
Number of drivers killed per unit distance of travel	4.87	3.64	3.23	1.83
Estimated driver involvements in severe crashes per licensed driver	3.79	8.99	2.90	4.29
Estimated driver involvements in severe crashes per unit distance travelled	7.58	10.32	4.61	4.07
Drivers involved in single vehicle crashes in which pedestrians are killed	2.77	8.45	2.96	10.47
Drivers per capita involved in single vehicle crashes in which pedestrians are killed	1.83	3.58	2.04	5.45
Drivers per licensed driver involved in single vehicle crashes in which pedestrians are killed	1.84	3.50	2.08	4.08

Drivers per unit district involved in single vehicle crashes in which pedestrians are killed	3.28	3.56	3.47	3.97
Probability that a given death is a motor vehicle fatality	4.86	55.14	5.59	43.13
Longevity increase per capita if all motor vehicle fatalities eliminated	3.25	12.44	2.28	6.55
Total longevity increase if all motor vehicle fatalities to specific age eliminated	6.05	27.60	4.17	10.23

Table 6.2 below sets out a male/female comparison for age 20, 40 and 65. As can be seen, males have higher rates for all but one case. The exception is at age 65, when the probability that a given death is due to a motor vehicle accident is higher for females than males (0.92). Professor Evans logically views this as no surprise in that "mortality due to all causes except motor vehicle crashes is almost twice as great for 65-year-old males as for 65-year-old females."[12]

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[12] Evans, "Fatal and Severe Crash Involvement."

TABLE 6.2

VARIABLE	MALE TO FEMALE RATIO Age=20	Age=40	Age=65
Number of drivers killed (in any type of motor vehicle)	4.88	3.31	2.70
Number of drivers killed per capita (in any type of motor vehicle)	4.84	3.44	3.20
Number of drivers killed per licensed driver	4.16	3.49	2.51
Number of drivers killed per unit distance of travel	2.09	1.38	1.05
Estimated driver involvements in severe crashes per licensed driver	5.41	4.14	2.59
Estimated driver involvements in severe crashes per unit distance travelled	2.71	1.65	1.07
Drivers involved in single vehicle crashes in which pedestrians are killed	3.21	3.43	.07
Drivers per capita involved in single vehicle crashes in which pedestrians are killed	3.18	3.56	4.84
Drivers per licensed driver involved in single vehicle crashes in which pedestrians are killed	2.90	3.27	3.38
Drivers per unit distance involved in single vehicle crashes in which pedestrians are killed	1.23	1.30	1.37

Probability that a given death is a motor vehicle fatality	1.18	1.36	0.92
Longevity increase per capita if all motor vehicle fatalities eliminated	2.41	1.69	1.27
Total longevity increase if all motor vehicle fatalities to specific age eliminated	3.07	2.11	1.14

Table 6.2 clearly demonstrates the increased risk presented by male drivers compared to female drivers. For example, using the first variable - number of drivers killed in any type of motor vehicle accident - Evans' data show that 4.88 times as many 20-year-old males are killed in motor vehicle accident as 20-year-old females; 3.31 times as many 40-year-old males are killed in motor vehicle accidents as compared to 40-year-old females; and 2.70 times as many 65-year-old males are killed in motor vehicle accidents as compared to 65-year-old females.

Young drivers are more of a risk to the system than older drivers. Male drivers are more of a risk than female drivers. Thus, if age and sex are eliminated, it seems to me that the threshold question is what, if anything, will replace those rating variables. The critical question then becomes how effective those replacement variables will be, having in mind the relevant evaluation criteria and sound insurance principles.

The proposed classification system eliminates age and substitutes years licensed as a rating variable. At page 14 of the draft classification system, the following appears:

YEARS LICENSED

Years licensed is a new concept applied to both primary and secondary drivers, as follows:

Principal driver	Secondary driver (the least experienced driver in household in residence)
<3 years	<3 years
<3 with driver training	<3 years
3 - 6 years	3 - 6 years
7 - 14 years	7 + years
15 - 34 years	
35 + years	

In the proposed classification system the substitute variable for sex is kilometres driven. At page 13 of the proposed classification system the following appears:

USE OF VEHICLE

Four categories of use with four distance bands will be employed, as follows:

Use	Low	Medium	High	Very high
Pleasure	<7,500 km	7,500 - 20,499	20,500 - 35,499	35,500 +
Short commute (regular 1-way drive <10km)	7,500 km	7,500 - 20,499	20,500 - 35,499	35,500 +
Long commute and business (>10 km)	<7,500 km	7,500 - 20,499	20,500 - 35,499	35,500 +
Farm	<7,500 km	7,500 - 20,499	20,500 - 35,499	35,500 +

Although the proposed classification system recognizes that age and sex cannot be abandoned without the introduction of substitute rating factors, substituting years licensed for age and kilometres driven for sex may be a somewhat cosmetic exercise. First, most brokers and agents who exercise a front-line underwriting function will know the approximate age of an applicant for automobile insurance. Sex is even more obvious. The underwriting function involves the assessment of a particular risk on its own merits. At that level neither age nor sex is likely to be ignored. There is an inevitable relationship between a classification system, underwriting, marketing and administration. Any consuming faith that abandoned rating variables, if otherwise reliable, will be eliminated by the introduction of a new classification, is, I think, somewhat naive. This is particularly true if substitutes are not perceived as being reliable. For example, at the administrative or underwriting level, insurers may conclude that premiums paid by young males will not meet expected losses and premiums paid by young females will be more than adequate to meet expected losses. This recognition will result in insurance being less available to males. It is probable in the circumstances set out above that the number of young male drivers in the Facility Association will increase.

If the purpose of the exercise is to eliminate age as a rating variable, we might consider whether, in substance as opposed to form, that has been accomplished by the introduction of years licensed. Take, for example, the proposed classification system's first "years licensed" group (0-3 years). What drivers will be in this group? The vast majority of the sub-group with zero to three

years driving experience will consist of drivers under 20. That is not surprising and in a sense validates the use of years licensed as a substitute for age. It also raises the question of the purpose of the exercise. If the substitute is to consist almost entirely of drivers of a certain age it seems unrealistic to obscure the issue by ignoring age as a rating variable.

The data suggest that young inexperienced drivers present a greater risk than older inexperienced drivers. If this is true, then substituting years licensed for age is an imperfect solution and it will probably result in cross-subsidization. Why this is so has been recently dealt with by Professors Matthews and Moran at the University of Guelph.[13] They noted:

> Although young drivers' estimates of accident involvement in the next year were higher than those of older drivers, young drivers gave lower ratings of accident risk for specific driving situations which demanded fast driving reflexes or substantial vehicle-handling skills. Young drivers rated their own risk of an accident and driving abilities as being the same as for older drivers. However, they saw their peers as being significantly higher at risk and having poorer abilities than themselves. Young drivers were more confident in their driving abilities than the older drivers. Evidence is provided to suggest that perceived risk and self-perceived driving abilities are interrelated.

In summary, in my opinion the policy decision to eliminate age as a rating variable is suspect for these reasons:

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[13]M.L. Matthews and A.R. Moran, "Age Differences in Male Drivers' Perception of Accident Risks: The Role of Perceived Driving Ability," Acc. Anal. and Prev. 18, no. 4 (1986): 299.

(1) given the probable age of members of any classification cell defined by years licensed, substituting years licensed for age will not in substance eliminate age as a rating criterion.

(2) years licensed is an imperfect substitute for age, in that it does not take into account data which consistently demonstrate that young newly-licensed drivers present a greater risk than older newly-licensed drivers.

(3) in any event, underwriters will be aware of the age of principal and occasional drivers even if specific information in that regard is not required on an application for insurance.

In expressing this opinion I recognize there may well be a constitutional bar to age-based premium rating.[14]

Unlike age, sex in its own right is not predictive. Sex is resorted to for premium rating purposes only as a proxy. It is a substitute for exposure variables such as kilometres driven, the propensity of women to drive at less high risk times than men and the propensity of women to drive less frequently while impaired. In the proposed classification system, sex has been replaced by kilometres driven as a rating factor. Even if this substitute is reliable it will expose the system to increased verification costs which will be passed on to the consumer in the form of increased premiums. There is also the question of the reliability of kilometres driven as a rating factor. In this regard it should be noted that the crucial issue is not the number of kilometres the

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[14] See Chapter 14 and Appendix XII.

applicant for insurance has driven over the past year, but rather the number of kilometres that will be driven in the period for which coverage is provided. The proposed system assumes that consumers will be both candid and accurate in their predictions. Human nature being what it is, neither assumption may be warranted. A complicating matter is that the insured must estimate the kilometres that will be driven by any occasional drivers. While the validity of continuing to use sex as a rating variable is questionable because of a legitimate concern over its constitutionality,[15] one should not be oblivious to the difficulties created by replacing it with kilometres driven.

Some have suggested that increased premiums for young females and young married couples is an inevitable result of abandoning sex as a rating variable. That is what happened in Montana where legislation eliminating sex and marital status (not age) became effective on October 1, 1985. Table 6.3 sets out the effects of unisex rating on premiums in Billings, Montana in 1985.[16] Those who won and lost, from a premium standpoint, can clearly be seen from Table 6.3.

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[15] See Chapter 14 and Appendix XII.

[16] This Table has been reproduced from "Unisex Insurance Rating - Montana's Failed Experiment," J. of Am. Insurance 3rd Quarter (1987).

TABLE 6.3

EFFECTS OF UNISEX RATING ON AUTO INSURANCE

PREMIUMS IN BILLINGS, MONTANA, 1985

Rating Class	Average premium 9/30/85 (before unisex rating) $	Average premium 10/2/85 (after unisex rating $	Average change in premium $	Average percent change in premium %
17-year-old single (occasional driver)	880.59	781.23	-199.36	-11.3
17-year-old female (occasional driver)	634.68	781.23	+146.57	+23.1
19-year-old male (principal driver)	1,181.56	934.64	-246.92	-20.9
19-year-old female (principal driver)	686.40	934.64	+248.23	+36.2
23-year-old male (principal driver)	855.35	644.41	210.94	-24.7
23-year-old female (principal driver)	537.83	644.41	+106.58	+19.8
23-year-old male (principal driver)	508.09	647.33	-139.24	+27.4
23-year-old female (principal driver)	401.94	637.65	+235.72	+58.6
35-year-old single male	401.60	413.13	12.36	+3.1
35-year-old single female	386.98	413.13	26.15	+6.8
35-year-old married couple	401.94	416.04	14.11	+3.5

Note: Data was collected from 12 insurers accounting for approximately 72% of auto insurance premiums written in Montana in 1985.

The Montana results show that a 40-year-old couple with a 16-year-old daughter had an average increase of 33% in their automobile insurance premiums. If the same couple had a 16-year-old son, instead of a 16-year-old daughter, their rates would have declined 8%. The Montana study concluded quoting, and adopting, a Montana Department of Insurance conclusion, that those most affected by the unisex law, "were young women, young married couples and married couples with young female drivers."

The Montana rate increases were not benignly accepted as legitimate by Robert Hunter of the National Insurance Consumers Organization. Mr. Hunter suggested, "the insurers have engaged in political ratemaking in your small state to send a signal to the rest of the nation, 'back off neutral pricing'." Mr. Hunter supported his claim by pointing to the fact that average automobile insurance premiums in Montana rose 47% in 1985. Montana insurers rejected this argument, pointing out that the Montana unisex premium rating law did not take effect until October 1, 1985, and that Hunter himself had conceded insurers had sound economic reasons for rate increases in 1985.

American experience would suggest that abolishing sex as a rating variable will inevitably result in increased premiums for young women.[17] Young men still seem to get involved in more accidents and more severe accidents than young women, given the same distance driven. To that

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[17] See "Unisex Insurance Rating - Montana's Failed Experiment."

extent eliminating sex will result in women bearing an increased premium burden. What that burden will be should be made clear before the proposed classification system is implemented.[18]

Two further points remain. First, the premium increases to which young women are exposed will be substantial, because the population of young male drivers is much larger than the population of young female drivers. Second, even if kilometres driven turns out to be a reliable substitute, underwriters may not accept it as such. If this happens, underwriters will write the perceived overpriced female risks and reject the perceived underpriced male risks.

The proposed classification system should be discussed and evaluated outside the perimeters of the committee established to create it. Most importantly, the impact of the system on the premiums consumers will be required to pay should be disclosed and discussed. I strongly endorse the committee's recognition that the proposed classification system "is not at this time a final proposal, but rather a starting point for discussion of this complex matter".[19]

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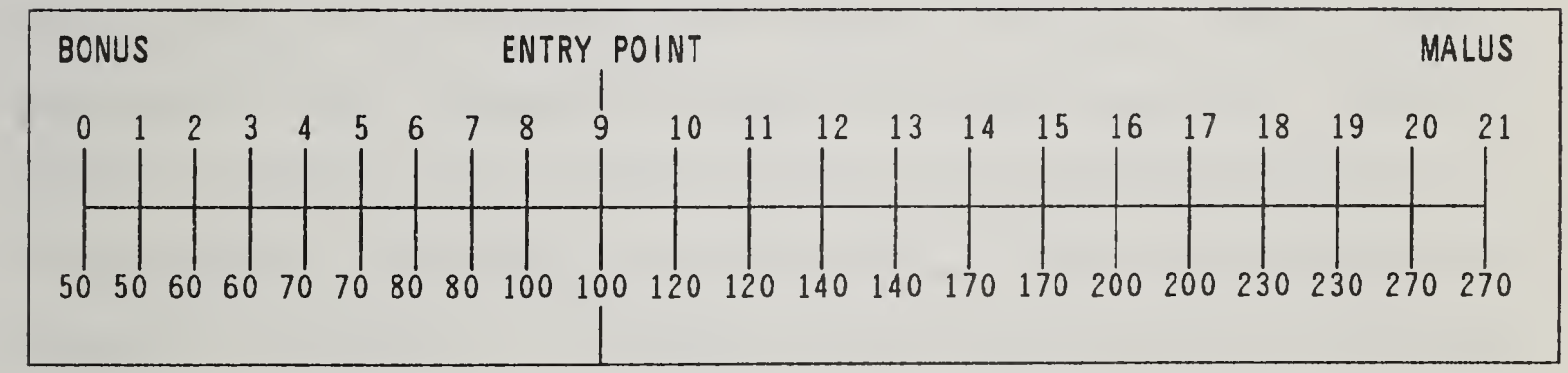
[18] Stephen R. Ryan, "The Elimination of Gender Discrimination in Insurance Pricing: Does Automobile Insurance Rate Without Sex?" Notre Dame L. Rev. 61 (1986): 748.

[19] See Proposed Classification System, Draft No. 2 (Appendix XVI, p.1).

E. BONUS/MALUS

No discussion of the principles underlying classification systems would be complete without some reference to bonus/malus. A bonus/malus system of classifying insureds was recommended by the Ontario Task Force on Insurance which looked to the Swiss bonus/malus model and the classification system used by the Insurance Corporation of British Columbia (I.C.B.C.).[20] The I.C.B.C. classification system incorporates the bonus/malus concept in its rate-making structure.

The bonus/malus rating most often referred to is the system used in Switzerland. The Swiss bonus/malus scale is reproduced below. Some explanation is required:



The entry point is 9. In the Swiss model this currently results in those entering the system paying 144% of the average premium. The system responds to at-fault claims against the policy. It does not matter who is driving the insured automobile. For every claim the insured is assessed three malus points against the policy.

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[20] Ontario Task Force on Insurance, Final Report (1986), p. 82.

For example, if there was a claim against the insured's policy at the year of entry, the insured would move from the entry point of 9 to 12. The insured moves one step in the bonus direction for each claim-free year. Premium reductions are implemented at two-year intervals.

The Ontario Task Force on Insurance in its Report referred to bonus/malus as part of its recommendation that "...incentives for good behaviour and penalties or deterrents for bad behaviour should be a part of the auto insurance system."[21] The implementation of bonus/malus was then recommended along with "...safe driving campaigns, better safety standards and equipment, and stricter Criminal Code sanctions...".[22]

The Task Force obviously recognized the need to adjust premiums in response to good (bonus) and bad (malus) driving. No reference was made to Quebec, but it follows that although the Ontario Task Force on Insurance recommended no fault automobile insurance, it rejected Quebec's flat premium rating system. In Quebec, the Régie makes no bonus/malus adjustment in response to claims or conviction experience.

I can readily accept the need to respond to good and bad driving experience through the automobile insurance system, as well as through criminal sanctions, etc. I

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[21] Ontario Task Force on Insurance, Final Report (1986), p. 81.

[22] Ontario Task Force on Insurance, Final Report (1986), p. 81.

reject flat premium rating;[23] however, I do not regard the introduction of a bonus/malus system on its own as being workable or consistent with the fundamental principles of insurance which, in a private sector delivery system, must involve grouping of insureds having similar risk characteristics for the purposes of setting premiums. Expected losses have to be assessed as part of the grouping exercise before any particular insured's driving and claims record is known.

Use of vehicle, kilometres driven, territory, years licensed, etc. are statistically sound predictors of risk. A pure bonus/malus system requires the abandonment of these rating variables.[24] The necessity in a pure bonus/malus system of charging demonstrably unequal risks equal premiums at entry violates basic insurance principles and leads to cross-subsidization. That is not to say that an insured's accident record, and for that matter, convictions, have no place in premium-setting. They cannot, however, be used alone. They must be part of a sound classification system consistent with fundamental principles of insurance. Ontario's insurers have always taken account of an insured's accident record in setting premiums. The proposed classification system makes no change in the application of this principle.

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[23] Professor Gaudry's Inquiry Research Study and his Report on the Régie, both provide a useful insight into the impact of flat premium rating.

[24] This may be compared with, for example, British Columbia where a bonus/malus system is used along with some rating variables.

In British Columbia, the I.C.B.C. eliminated age, sex and marital status as rating criteria and at the same time introduced a form of bonus/malus which it called "The Claim-Rated Scale". Although the system has a populist appeal, when examined in light of sound insurance principles, it is manifestly unfair. The I.C.B.C. system results in low risk drivers paying higher premiums than insurance principles say should be the case. The surcharges levied after the fact (and more likely on the higher risk drivers) dilute but do not eliminate this unfairness. As discussed in Chapter 15, this system is unworkable in a private sector delivery system.

How then does bonus/malus seem to work in Switzerland? In Switzerland, 50% of automobile insurance is sold by two insurers. Those two insurers, together with the government, set premium rates. A certain profit margin is built into the rate-making structure. Insureds rarely change insurers. There is no incentive in the system for the consumer to shop around or for insurers to seek to secure business written by other companies, and in that way to increase market share. Competition, as we know it, does not exist. Real competition is restricted to securing the business of those just entering the system. Just as cross-subsidization can be tolerated in a monopoly delivery system (such as exists in jurisdictions where automobile insurance is provided by the government) it can be tolerated in Switzerland's unusual private sector environment.

We must have a classification system which is fair, reliable and objective. Once such a classification system

is established, cross-subsidization will be avoided.[25] In general, a bonus/malus system will not only not avoid cross-subsidization, it will likely lead to it.

On a more specific level, I have these comments as to the operation of a bonus/malus system such as exists in Switzerland:

(a) In the Swiss bonus/malus model, the point of entry has been somewhat arbitrarily established. All insureds who enter the system enter at 9. To the extent that new entrants are young drivers, age is not eliminated as a rating variable; nor, of course, is experience, provided the new entrant has no driving experience. New entrants who are experienced drivers, such as those entering the system from another jurisdiction are grouped with those who have limited or no driving experience. Grouping within bonus/malus is accomplished at the point of entry in the sense that all entering are required to enter at the same point (9). This flat premium rating at entry results in manifestly bad risks paying the same premium as good risks. The result is that good risks subsidize the bad risks.

(b) Surcharges and premium reductions are structured without regard to the system's expected loss

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[25] Cross-subsidization does occur through the residual market (the Facility Association). Because automobile insurance is compulsory both the government and automobile insurers recognize the need for a residual market. The system can tolerate limited cross-subsidization at that level.

costs. If there is a systemic shortfall, the premiums of all drivers in the system, good and bad, have to be increased. There is little capacity to predict how many drivers will be at various bonus/malus scale levels. This can lead to a lack of stability on the premium side. The solution, once again, is the cross-subsidization of bad drivers by good drivers.

(c) Premium increases and decreases are directly linked to bonus/malus points; relative premium adjustments in response to bonus or malus points are hence predetermined without regard to expected loss costs. If the surcharges imposed on at-fault drivers are insufficient to pay expected loss costs as they always are (because of the relatively few number of accidents), then everyone in the system has to make up the difference. Once again cross-subsidization is the result, although it is reduced to the extent at-fault drivers are surcharged.

(d) In order to operate with any degree of efficiency, a bonus/malus classification system requires full exchange of information among insurers. This is not a major problem in Switzerland in that there are 26 companies and two of them have secured approximately 50% of the automobile insurance business. Moreover, as earlier stated, insureds in Switzerland rarely change insurers.

(e) Injustices can occur because malus points are triggered by claims against the policy, quite

apart from the identity of the driver of the insured automobile at the time of an accident. An occasional driver's negligence may result in claims being made against the policy. The owner of the vehicle bears the burden of the resultant premium increase, not the occasional driver. The potential injustice of this can be emphasized by an example. If a teenage occasional driver's negligence in the operation of the family car causes two accidents, the owner of the car will acquire six malus points. If those malus points are imposed from the entry point (9) the insured will be relegated to a 15 rating on the bonus/ malus scale. Fifteen claims-free years will have to elapse before the insured is able to secure the best premium rating (0). Six claims-free years will have to elapse before the insured returns to the point of entry (9). At the same time, the teenager may have left home and purchased a new automobile, at which point the teenager is insured at an entry point of 9. I do not regard this as fair.

(f) Bonus/malus responds well to at-fault accident experience; Switzerland has no first party no fault benefits such as we have in Section B of the standard automobile policy. In Switzerland claims against the policy which trigger malus points are third party or collision claims where the insured is regarded as being at fault. A malus adjustment for first party benefits (as exist in Ontario) would not be tolerated in cases where the insured was not at fault. I note that

the I.C.B.C. makes no malus adjustment for first party claims against the policy.

(g) In the Swiss bonus/malus scheme, eight years of driving without claims experience will result in the lowest premium rating. In Ontario, the preferred premium rating is achieved by those who have six claims-free driving years.

In Switzerland, age and driving experience are recognized by resort to a third party deductible system. Swiss insurers explained that their third party deductible system is used because of the high accident frequency and severity of young and inexperienced drivers.[26] I regard such a system as separate from bonus/malus and impractical in Ontario where insureds frequently change insurers.

In Ontario those with good driving records pay lower premiums and those with bad driving records are exposed to premium increases. This is a bonus/malus-like response to good and bad driving. What generally distinguishes Ontario's system from the bonus/malus system in Switzerland is that in Ontario not all drivers coming into the system pay the same premium because Ontario insurers and the government reject the principle that all drivers initially represent an equal risk to the system; further, in Ontario, premium increases and decreases are not predetermined but are related to the system's expected loss costs.

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[26] For details of the Swiss third party deductible system see Ontario Task Force on Insurance, Final Report (1986), p. 81.

F. UNDERWRITING

The classification system should not be considered in isolation. Insurance is delivered to consumers through the classification system and the underwriting process. Underwriting is the process of assessing each risk on its own merits. As the Canadian Institute of Actuaries has pointed out,

> In practice, the application of the underwriting function controls the practical impact of the classification system, and misapplication of the classification system in the underwriting process will achieve results different from those intended.[27]

Each insurer has its own underwriting risk evaluation system. Insurers attempt to determine risk characteristics and assess those characteristics over a broad relevant population base to develop a statistical measure of risk quality. Insurers seek to develop a relationship between accident frequency (and, in some instances, severity) and identifiable statistically measurable risk characteristics. The interrelationship among many risk characteristics is assessed on an individual basis as part of the underwriting process. Risk characteristics are often weighted; some are obviously more important than others.

What risk characteristics are considered varies from insurer to insurer. One major insurer uses 37 separate underwriting factors; another (and smaller) insurer uses

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[27] See Canadian Institute of Actuaries, Risk Classification.

four. The majority of insureds are dealt with from an underwriting standpoint at the broker or agent level. Many brokers have authority to bind the insurer to a risk. The broker or agent follows the insurer's underwriting policies.

Underwriting criteria used by insurers are not necessarily causal; in their application they are said to establish a correlation with accident probability. For example, pure stability underwriting criteria such as residence ownership, years at residence and years at present employment are used for underwriting purposes by some insurers. It can be argued that how long a person has resided at a given residence can have nothing to do with the probability of that person being involved in an accident. No one could elevate the connection with accident probability to more than a correlation.

I have referred to home ownership not because it is unusually important, but rather to illustrate that insurers have the view that home owners, particularly those who have lived in the same residence for more than a brief time, are less likely to be involved in an accident than similarly situated risks who do not own homes. Home ownership, of course, means little or nothing on an individual basis. If, however, the accident experience of a large number of insureds is taken into account, the accident experience of homeowners is said to be better than the accident experience of those who do not own their own homes. There is in that sense no causal connection between home ownership and accidents, merely a correlation.

Underwriting practices also have significant consequences in the substandard market. The few companies competing for business that the regular market will not write, attempt to identify risks that are surchargeable, but which can be profitably underwritten in that grey area between the regular market and the Facility Association. As earlier stated, some substandard insurers will underwrite a person convicted of impaired driving, but not a newly-licensed driver. This represents further evidence that however sophisticated an insurer's underwriting policies may or may not be, age and driving experience is a significant underwriting factor. Elimination of age in the classification system will not result in its demise as an underwriting factor. The same can be said of sex and to a lesser extent marital status.

The somewhat pejorative term "creaming" is applied to the underwriting process when it rises or descends (depending on your point of view) to the point where preferred risk selection becomes central to an insurer's underwriting and marketing policies. In a very general way, some companies seek to insure demonstrably good risks at relatively low premiums, as opposed to poorer risks at higher premiums.

In Chapter 4, dealing with Marketing, I referred to insurers' demands of brokers related to mix of business and accompanying business. These requests generally force brokers to secure a certain number of homeowners' policies per automobile policy written (mix of business); or the broker is required to write the homeowner's policy in addition to an automobile policy before the insurer will accept an applicant's automobile insurance business (accompanying business). I have reviewed some cases where

the accompanying business edict was embellished by the additional requirement that the home to be insured in the accompanying business package have a certain minimum value. This kind of underwriting and marketing has nothing to do with the classification system; however, it affects the consumer's access to insurance in a very real way. Accompanying business and mix of business demands obviously result in the insurer writing additional business. Homeowner's insurance tends to be more profitable than automobile insurance. There is, however, more to it than that. Requiring an insured who seeks automobile insurance to purchase homeowner's coverage is a form of "creaming" in that it isolates only those applicants for insurance who own a home to insure. As stated earlier, homeowners are thought by most insurers to be better risks than non-homeowners.

Some insurers regard the frequency with which an applicant for insurance has changed automobile insurers as an underwriting factor of some significance. One insurer's rate book provided that if a person seeking automobile insurance had more than three different insurers in the past five years, the business was not to be underwritten.[28] This automobile insurance promiscuity factor is mostly cost, as opposed to risk-related. Loss ratios on new business are higher than loss ratios for

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[28]The insurer to which I refer based its decision not to insure anyone who had changed insurers more than three times in the past five years on two factors: (a) loss ratio of new business said to be 20-25% higher than the remainder of the insurer's portfolio; (b) the cost of underwriting, processing and issuing a new policy was $92 and the cost of renewing an existing policy was $10.

renewal business. This is because insurers have an actual experience record to work on with respect to old business; insurers will cancel or not renew existing business that is deemed to be too risky. Further, the administrative expense attendant upon the renewal of a policy is significantly less than the administrative expense attendant upon writing new business. The policy of refusing to write applicants for automobile insurance who have changed insurers too frequently is unacceptable. If this policy became widespread it would for all practical purposes render the private sector delivery of insurance irrelevant, in that true competition and the right to choose insurers is the substantive benefit derived from the private sector provision of insurance. The resort to the number of insurers anyone has had over any particular timeframe should be prohibited, and deemed an unfair underwriting practice.

The relationship between the classification system, underwriting and marketing cannot be ignored. All have a direct impact on both the availability of insurance in the regular market, and its cost. Even if insurers were required to take all comers, there would be underwriting complaints, although they likely would be fewer in number than is now the case.

It seems to me that there are two major problem areas as I assess underwriting-related complaints. First, because vehicles, not drivers, are insured, the risk presented by an occasional driver, as well as the risk presented by the named insured, is quite properly taken into account at the underwriting level. This can have a significant effect on premiums. For example, an insured whose spouse (an occasional driver) has been convicted of

impaired driving, is exposed to a substantial premium increase because of the occasional driver's driving-related criminal record. Another common example is the insured who has a teenage son of driving age listed as an occasional driver. This, too, causes an increase in the insured's premium.

Because the insurance contract insures the named insured and anyone driving the insured automobile with the named insured's consent, insurers have to take the risk presented by occasional drivers into account. In light of the terms of the insurance contract, it is not surprising that insurers are reluctant to accept the assertion a particular occasional driver will not be given consent to drive the insured automobile. On the other hand, insureds who have no intention of consenting to an occasional driver's use of the insured automobile feel justifiably aggrieved by having to pay a higher premium. In many instances, consumers have attempted to convince the insurer that a particular person will not be permitted to drive. To remedy this situation, provision should be made to exclude named occasional drivers from coverage, in circumstances where both the named insured and the occasional driver have acknowledged in writing that coverage is not sought and is not to be extended to the named occasional driver.

The Superintendent of Insurance has taken steps to make this relief available through what is known as the automobile industry's "spouse in the house" coverage exclusion. The Superintendent's initiatives should be pursued to a conclusion. This will have a substantial effect on premiums in some cases.

If that coverage exclusion were to be implemented, the excluded occasional driver would be in violation of the Compulsory Automobile Insurance Act,[29] were that driver to be driving the insured vehicle at all. A new offence should be created so as to penalize the named insured in those cases where the named insured has given consent to the excluded occasional driver's use of the insured vehicle. A new offence short of theft and in addition to driving without insurance should be established to penalize an excluded occasional driver who has driven the insured's car with or without consent.

In the final analysis, it is essential that the named insured and the excluded occasional driver appreciate that the excluded occasional driver cannot drive the insured motor vehicle from both an insurance coverage standpoint, and from the standpoint of quasi-criminal sanctions which will be attracted by the excluded occasional driver's use of the insured vehicle.

G. UNDERWRITING AND THE FACILITY ASSOCIATION

Supposedly, drivers in the Facility Association cannot obtain insurance in the regular market. One might think that all drivers in the Facility Association would, therefore, have some combination of accidents and convictions, etc. that resulted in those drivers being relegated to the Facility Association. Facility Association records, however, disclose that 29% of drivers in the Facility Association are clean drivers. Clean drivers are

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[29]R.S.O. 1980, c. 83.

those drivers who have driving/conviction records which do not expose them to surcharges.

There is a substantial difference between Facility Association premiums and regular market premiums. Many think that clean drivers in the Facility Association should not be exposed to the Facility Association premiums. A number of questions arise. Why are those clean drivers in the Facility Association in the first place? Should those clean drivers in the Facility Association be exposed to the relatively large premium differential above referred to? There is no one answer to the first question. Most clean drivers in the Facility Association are there because an agent or broker or an insurer's internal underwriting department somehow concluded that there was something inappropriate about the risk. This is sometimes, but not always, more than underwriting by intuition. On some occasions, legitimate underwriting suspicions will arise. A common example is the situation presented to a broker acting as an insurer's front line underwriter when an insured who seeks insurance may be thought not to be the true owner of the vehicle for which coverage is sought. Because insurance is expensive for those with accident or conviction records and for young drivers, some seek coverage through a person located in a lower risk cell of the classification system. An example given to me was a grandmother who attempted to insure "her" 1986 Corvette. The car, in reality, was not owned by the person seeking coverage.

In that I viewed examples like this as somewhat isolated, I initially concluded that it was simply wrong that 29% of drivers in the Facility Association were clean drivers. The I.B.C. seemingly agreed. It was

proposed that those drivers with four or more "events"[30] against the insured's driving record in the past three years would be relegated to the Facility Association, but those with less than four events in the past three years, if unable to obtain regular market coverage, would go into the Facility Association pooling arrangement at the insurer's regular book premium. The President of the Insurance Bureau of Canada put it this way:[31]

> Perhaps the intent is best summarized by the statement on page 10 of our Supplementary Submission that 'business going into the Association will consist of risks which the voluntary market should not be expected to assume'. In very broad terms, a risk would definitely not be forced into the Facility Association simply because of inexperience regardless of age nor would a risk with one or two accidents and/or Highway Traffic Act violations. These would be eligible for pooling and, as such, would be written at the insurer's normal premiums for such a risk. The rates would of course be higher than rates for experienced drivers without accidents or convictions but would <u>definitely</u> be less than Facility Rates.

I endorse the concept of subdividing Facility Association private passenger business between demonstrably bad risks, and those which cannot be so described. It seems to me, however, that caution is required. It is tempting to conclude that clean risks do not belong in the Facility Association. That conclusion

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[30]The following will outline what the I.B.C. regards as an event: "Three minor Highway Traffic Act convictions equals one event. Every two additional minor Highway Traffic Act convictions equals one event. Every major Highway Traffic Act conviction equals one event. Every Criminal Code or serious driving related conviction equals two events. Every accident equals one event."

[31]See letter from J. L. Lyndon, (September 30, 1987).

is, of course, premised upon the assumption that the regular market should insure so-called clean drivers. If, however, the clean driver/Facility Association issue is taken one step further, it would appear that on an aggregate basis, underwriters may well have been correct in declining to write some of the claims business that was referred to the Facility Association. At my request, the General Manager of the Facility Association secured loss ratio information referable to the clean driver population of the Facility Association. Clean drivers in the Facility Association had a loss ratio of 214. The clean driver loss ratio was conspicuously higher than the loss ratio for surcharged drivers in the Facility Association. It is reasonable to conclude that on an aggregate basis, underwriters refusing to write those clean drivers that are now in the Facility Association, were correct. This means, of course, that if premiums are reduced for that part of the Facility Association population, the loss ratio will be even higher. The remainder of Ontario's drivers are already subsidizing Facility Association drivers in that Facility Association premium rates are not sufficient to meet expected loss costs. It must be recognized that any steps taken to lower rates in the Facility Association will in all likelihood lead to further cross-subsidization.

Nevertheless, there is an existing problem with respect to clean drivers in the Facility Association who should not be there in the first place. Assuming the Facility Association/regular market premium gap is to be narrowed, at least for clean drivers, the loss experience of that pooled group should be continually monitored. Steps should be taken to attempt to identify those clean risk drivers who demonstrably do not belong in the

Facility Association from those risks, clean or otherwise, that the regular market cannot reasonably be expected to underwrite. I will deal with Facility Association rates and their regulation together with related social policy issues in Chapter 16.

Finally, during the course of this Inquiry, the I.B.C. and the I.B.A.O. in a bulletin dated March 10, 1987 jointly sought to come to grips with the problem of so-called "grey" risks. These "grey" risks constitute many of the 29% clean drivers in the Facility Association. The I.B.C./I.B.A.O. perception of the problem and proposed solution warrant full reproduction of the bulletin to which I have just referred. It is as follows:

March 10, 1987

MEMORANDUM

TO: Every Ontario Insurance Broker

FROM: Steve Kaluski
President
Insurance Brokers Association of Ontario

John L. Lyndon
President
Insurance Bureau of Canada

RE: Automobile Insurance Marketing Changes

Everyone employed in Ontario's property/casualty insurance industry is aware by now of the possibility of the nationalization of Ontario's car insurance business. We are pleased to announce some of the initiatives that have been undertaken by members of the Insurance Bureau of Canada which we feel will help to preserve the present system.

Starting immediately, the Chief Executive Officers of most of Ontario's insurers have instructed their staff to relax the very strict underwriting rules which have been employed in recent months. Companies will once again entertain submissions of so-called "grey" risks

which have been heretofore arbitrarily consigned to the Facility Association. Although each company will independently define these risks, it is important that you realize that there is now an overall consensus to accommodate these drivers in the regular market.

As brokers, you too can play an important role in the voluntary depopulation of the Facility Association. You are now asked to take the extra effort and resubmit each of your Facility Association clients to a regular market underwriter at renewal. Although some risks will still be declined, many current FA clients will be written in the regular market henceforth.

There is also another matter that the CEOs want clearly understood. If an underwriter refuses to accept a piece of business which, in your opinion, qualifies as a regular market risk, the Chief Executive Officer of that company wants to hear about it. By bringing the matter to his attention, you will simply be making the CEO aware of the underwriter's non-compliance with his wishes. Do not be afraid to contact the senior management of any insurer. IBAO members, of course, can direct their complaints to the IBAO Toronto office for handling.

The members of the Insurance Brokers Association of Ontario and the companies that belong to the Insurance Bureau of Canada are working together to preserve the private enterprise insurance business in this province, and if we all do our part, we will be successful.

This bulletin speaks for itself. It verifies and summarizes the reality of underwriting abuses which existed through 1986 and into 1987 and in some respects continue to exist.

H. SPECIAL CASES (MOTORCYCLES, ALL-TERRAIN VEHICLES, TAXIS AND TRUCKS)

(a) Motorcycles

Motorcycles present a problem from the standpoint of first party no fault coverage. Motorcycle drivers and passengers are clearly vulnerable to injury. In result,

any increase in Section B benefits will have a greater impact on motorcyles than on private passenger automobiles. Motorcycles represent approximately 2.9% of the vehicle population; 7.4% of motor vehicle-related fatalities involve motorcycle deaths; 4.2% of bodily injury cases involve motorcycle operators or passengers.[32] Those injured on motorcycles, being relatively unprotected, tend to suffer more severe injuries than those injured in automobile accidents.

Groups representing motorcycle owners and operators are concerned about motorcycle Section B no fault premium levels. Those groups also expressed concern with the insurance industry's propensity to premium rate motorcycles based upon engine size. The submission of the Motorcycle and Moped Industry Council makes the point that accident involvement of motorcycles is not related to engine size. That point is well taken. Severity, however, has to be considered.

A further problem exists with motorcycles. The owner/driver population in that sub-group tends to be young. The I.B.C. stated in its supplementary submission that 67% of those killed in motorcycle accidents were under 25.

The proposed classification system rates motorcycles, for Section A third party bodily injury property damage coverage, by territory, engine size and years licensed. The surcharges for claims and convictions are to be the same as for private passenger automobiles. Section B

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[32] See I.B.C.'s supplementary submission (August 1987).

rating is by territory, engine size and recognizes the distinction between on and off-road motorcycles. I will deal specifically with motorcycle coverage and premium rating in Chapter 12.

(b) All-terrain vehicles

There are an increasing number but still relatively few of these vehicles. The Motorcycle and Moped Industry Council has suggested that risk assessment and premium determination for all-terrain vehicles has been done by the insurance industry in a "closeted atmosphere". I hope this concern will be eliminated by full discussion of the proposed classification system. It is suggested that three-wheel all-terrain vehicles are rated in the same way as on-road motorcycles in the face of the Ministry of Transportation and Communications' data indicating that this is inappropriate. The basic premium-rating for three-wheel all-terrain vehicles, four-wheel all-terrain vehicles and other off-road vehicles, such as snowmobiles, is brought into question by the Motorcycle and Moped Industry Council. This should be examined as part of structuring the new classification system.[33]

(c) Taxis

Taxis present a unique premium problem. This problem has received much media exposure during the past year. Not surprisingly, the problem is the extraordinarily high premium level to which some taxi operators in Ontario are

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[33] See Motorcycle and Moped Industry Council's Submission, p. 4 and Appendix B.

exposed. Various associations representing taxi operators have sought relief from these high premiums. The main problem area is Toronto. The Toronto Taxicab Brokerages Association (T.T.B.A.) made a submission to me and to the Minister of Financial Institutions seeking relief through government intervention or, if need be, government-delivered automobile insurance.

The root cause of the taxi industry's premium problems is high loss costs. Even at the high current premium levels, the Facility Association, which insures 46% of taxis in Ontario and 50% of taxis in Toronto, is losing money on its taxi business.[34] Premiums, in other words, are too low. Ontario motorists generally are subsidizing taxis, and taxi operators outside of Toronto are subsidizing taxi operators located in Toronto. It is quite apparent that in short order, the private sector insurance industry will view fleet taxis (taxis not owner-operated or run through a legitimate co-operative) as close to uninsurable in the regular market, if significant improvement in taxi-related losses is not forthcoming.

Representatives of the taxi industry do not deny the horrendous loss costs. In the T.T.B.A.'s submission to the Minister of Financial Institutions it is suggested that at least one of the causes of the problem is "...the aggressive nature of many drivers...". That submission also refers to "...an exceptionally high turnover rate of drivers in our industry, resulting in a high number of inexperienced drivers on the road." The T.T.B.A. also

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[34] See Facility Association, "Presentation to Metropolitan Toronto Licensing Commission" (June 22, 1987).

blames the insurance industry as a whole for not better informing taxi drivers of the benefits of good driving and the risks attendant upon bad driving. The insurance industry deserves criticism for many things but failure to explain the benefits of safe driving to taxi drivers can hardly be included in the list.

The taxi industry may have come to grips with the need for risk management, including more direct involvement of the owner of a taxi licence with the operation of the taxi, better control over drivers and their records, more specific licensing requirements and the introduction of a new classification of driving licence for taxi drivers.

In the 1987 Report of the insurance working group of the Metropolitan Licensing Commission, these and other recommendations were made. I endorse these recommendations, but remain pessimistic about the situation improving until the owners of taxi plates have a direct stake in who is driving the taxi and how it is driven.

It is obvious that there is no one solution to the taxi premium problem. Accidents involving taxis have to be reduced. Better driver education and control, perhaps through the use of incentives as suggested by Professor Wilde in his Inquiry research study, would be a step in the right direction.[35] In the meantime, taxis will be increasingly insured in the residual market. Premiums for taxis in the residual market are far below what expected loss costs would suggest those premiums should be. A

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[35] See Inquiry Research Study VI.

social policy decision will have to be made as to the extent to which Ontario's drivers are to be asked to subsidize taxis. I recognize that there is a social need for taxis; in congested urban areas, such as downtown Toronto, taxis are a necessity. I have no basic objection to some degree of subsidization for taxis. It seems to be sadly inevitable. Something must be done about the root causes of the problem, which I view as being owner neglect, driver incompetence and instability.

(d) Trucks

Those representing the trucking industry, such as the Ontario Trucking Association (O.T.A.), express concern about the trucking industry's third party premium exposure. Just as motorcycles present a high first party premium problem, trucks present a high third party premium problem. It works this way: motorcycles cause relatively little damage to other vehicles or property, but first party motorcycle exposure is high because motorcycle drivers and passengers are relatively unprotected. On the other hand, trucks have the capacity to cause significant damage to others. Those in a truck are relatively well protected and are often covered for economic loss by the Workers' Compensation system. The result is that first party no fault premiums (Section B) are low for trucks and third party liability premiums (Section A) are high. The O.T.A., which represents approximately 800 trucking companies, endorsed a form of threshold no fault. The O.T.A. expressed distinctly qualified enthusiasm for pure no fault by recommending its adoption "as a last resort".

As I understand the O.T.A.'s position, non-pecuniary general damages should be limited "...unless a definitive

and foolproof tort threshold is reached...".[36] The object of the limitation suggested by the O.T.A. is the reduction, or at least the control, of insurance premiums at the third party level.

Although problems related to automobile insurance were generally thought to be separate from the liability insurance crisis of 1985-86, there is no doubt that the liability insurance crisis did have an effect on truckers' access to liability coverage and on the affordability of coverage which was available. The collapse of the United Canada Insurance Company (a company which insured about 40% of truckers) resulted in many truckers being cast adrift, and required to look elsewhere for insurance. The result was that the Facility Association truck population increased significantly by the end of 1986. The truckers' position is that when coverage is compulsory the government must see that it is provided at affordable rates. This position is taken notwithstanding the fact that truckers are engaged in commercial ventures in which costs, for the most part, are passed on.

The O.T.A.'s submission to the Ontario Task Force on Insurance emphasized coverage and affordability problems attendant upon the proclamation of legislation such as Part IX of the Environmental Protection Act.[37] Concerns about environmental exposure are beyond the scope of this

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[36] O.T.A. submission (February 1987).

[37] The so-called "Spills Bill", Part IX of the Environmental Protection Act, R.S.O. 1980, c. 141 was proclaimed in force November 29, 1985. See Ontario Trucking Association submission to Ontario Task Force on Insurance (March 21, 1986), p. 2.

report. However, any legislation which increases the exposure of an identifiable group, such as the trucking industry, should take insurance-related issues into account.

CHAPTER 7

LOSS COSTS AND PREMIUMS

A. LOSS COSTS

From an insurance standpoint, the crucial statistical measurements are the number of accidents per 100 vehicles insured and the loss costs attributable to those accidents. Unlike those having an interest in accident prevention, insurers focus on the number and severity of accidents per 100 vehicles insured, not the kilometres driven by those insured.

Table 7.1 below sets out the claims frequency per 100 cars insured in all provinces except for Manitoba and Saskatchewan.[1] The Quebec experience represents that of private sector insurers operating in Quebec, not the Régie.

In assessing any data dealing with claims, care must be taken with the definition of a claim. Although there is a direct relationship between a claim and an accident, the terms of reference are different. Insurers do not have a universal definition of what a claim is; therefore, caution must be exercised in dealing with individual insurer's claims-related data.

Table 7.1 has been included to show a claims frequency comparison between Ontario and other provinces. As long

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[1] Frequency data are not readily obtainable for Manitoba and Saskatchewan.

as the definition of a claim is consistent for those purposes, it does not matter what the definition is.[2]

Table 7.1

CLAIMS FREQUENCY PER 100 CARS INSURED*

BODILY INJURY AND PROPERTY DAMAGE[3]

JURISDICTION	1983	1984	1985	1986
Alberta	5.4	5.3	5.6	5.8
New Brunswick	5.3	5.5	5.3	5.4
Newfoundland	5.8	5.9	5.5	5.3
Nova Scotia	4.8	5.0	5.1	4.9
Ontario	5.4	5.9	6.0	5.6
P.E.I.	5.1	5.6	5.2	5.3
Quebec	8.2	10.1	10.3	10.0
N.W.T.	3.5	3.4	2.9	2.7
Yukon	4.0	3.5	3.6	4.5
British Columbia	7.8	7.8	8.1	8.6
Canada**	6.5	7.0	7.1	6.9

* A "car insured" refers to a single car insured for 12 months. Thus if two cars are insured for six months each or three cars are insured for four months each, the total in every case would be one "car year" of insurance.

** Does not include British Columbia, Manitoba, Saskatchewan or Quebec no fault.

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[2] Because the statistics for British Columbia are drawn from a different data source, it is impossible to verify the British Columbia claims frequency figures. It seems reasonably clear that the I.C.B.C. definition of a "claim" is different from the I.B.C.'s definition of a "claim". This difference would, at least in part, explain the relatively high British Columbia bodily injury claims frequency figures.

[3] Insurance Bureau of Canada Automobile Insurance Experience, 1985 (except data for British Columbia which were provided by the Insurance Corporation of British Columbia).

Table 7.2 provides a breakdown of Ontario bodily injury and property damage accidents, from the standpoint of both frequency and severity, in the years 1977 to 1986. Because bodily injury and property damage coverage is compulsory, the same number of vehicles were insured for bodily injury and property damage in each year.[4]

TABLE 7.2

ONTARIO BODILY INJURY/PROPERTY DAMAGE SUMMARY ($CURRENT)

BODILY INJURY

Year	Number of cars	Losses $	CPI	Loss per car	Costs per claim	Claims freq. /100 cars	Number of claims
1977	2,993,943	180,744,938	67.9	60	6,098	0.99	29,640
1978	3,155,064	223,283,879	73.9	71	7,077	1.00	31,551
1979	3,320,756	263,569,068	80.7	79	8,918	0.89	29,555
1980	3,420,996	325,747,239	88.9	95	10,580	0.90	30,789
1981	3,475,637	391,259,408	100.0	112	12,508	0.90	31,281
1982	3,513,525	416,726,552	110.8	119	13,478	0.88	30,919
1983	3,597,887	512,499,215	117.2	143	16,005	0.89	32,021
1984	3,743,562	632,447,098	122.3	169	16,563	1.02	38,184
1985	3,895,781	774,54,270	127.2	199	18,409	1.08	42,974
1986	4,028,116	860,303,263	132.4	214	19,594	1.09	43,906
PROPERTY DAMAGE							
1977	2,993,943	138,141,428	67.9	46	743	6.21	185,924
1978	3,155,064	159,918,836	73.9	51	802	6.32	199,400
1979	3,320,756	191,864,648	80.7	58	941	6.14	103.894
1980	3,420,996	217,582,188	88.9	64	1,078	5.90	201,839
1981	3,475,637	237,864,950	100.0	68	1,182	5.79	201,239
1982	3,513,525	222,930,350	110.8	63	1,249	5.08	178,487
1983	3,597,887	217,754,195	117.2	61	1,339	4.52	162,624
1984	3,743,562	254,711,958	122.3	68	1,400	4.86	181,937
1985	3,895,781	290,304,250	127.2	74	1,527	4.88	190,114
1986	4,028,116	318,022,175	132.4	79	1,739	4.54	182,876

Note: It should be noted that because of the I.B.C. definition of a claim, the figure for average cost per claim cannot be interpreted as cost per person.

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[4] This coverage is contained in Section A of the Standard Automobile Policy.

The loss costs per vehicle[5] for property damage have remained relatively stable. This stability exists even without adjusting the property damage loss costs per car for inflation. The property damage claims frequency per 100 cars insured has declined from a high point of 6.32 in 1978 to 4.54 in 1986. The bodily injury claims frequency per 100 cars insured has increased from a low (.88) in 1982 to a high point in 1986 (1.09).

Table 7.3 presents the same bodily injury/property damage breakdown as to losses, loss cost per car and average claims cost for bodily injury and property damage as in Table 7.2, but adjusted to 1981 dollars. It is apparent that property damage losses seem to be under control. Bodily injury loss costs increased slightly in 1986. As can be seen from Table 7.3, there has been a steady increase in bodily injury loss costs since 1982.

Tables 7.2 and 7.3 provide a clearer picture of the progression of bodily injury/property damage loss costs from 1977 to 1986. Both tables show the relative stability of property damage loss costs. The bodily injury picture is different. The average cost of a bodily injury claim has risen from $6,098 in 1977 to $19,594 in 1986, an increase of 221% (Table 7.2). In constant (1981) dollars the percentage increase in bodily injury average claims cost is 65% (Table 7.3). When bodily

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[5] The term "loss costs" as used by insurers and referred to here, includes claims actually paid and claims adjustment expense paid, reserves established for unpaid but reported claims and reserves established for claims incurred, but not reported (I.B.N.R. reserves).

injury claims costs are measured by vehicles insured it is apparent that bodily injury loss costs per car have risen from $60 in 1977 to $214 in 1986 (Table 7.2). This represents an increase of 257%. In 1981 dollars (Table 7.3), the increase is from $89 per car to $161 per car, an increase of 81%.

Figure 7.1 provides the same information as Table 7.2, except that the Figure 7.1 information is related to the

Table 7.3

ONTARIO BODILY INJURY/PROPERTY DAMAGE SUMMARY
(1981 Dollars)

BODILY INJURY

Year	Losses ($1981)	Loss/car (1981) $	Cost per claim (1981) $
1977	266,192,839	89	8,981
1978	302,143,274	96	9,576
1979	326,603,554	98	11,051
1980	366,419,842	107	11,901
1981	391,259,408	113	12,508
1982	376,106,996	107	12,164
1983	437,286,019	122	13,656
1984	517,127,635	138	13,543
1985	608,921,596	156	14,472
1986	649,775,879	161	14,799

PROPERTY DAMAGE

1977	203,448,348	68	1,094
1978	216,398,966	69	1,085
1979	237,750,493	72	1,166
1980	244,749,367	72	1,213
1981	237,864,950	68	1,182
1982	201,200,677	57	1,127
1983	185,797,095	52	1,142
1984	208,268,159	56	1,145
1985	228,226,612	59	1,200
1986	240,198,017	60	1,313

accident benefits part of the standard automobile policy.[6] The red bars in Figure 7.1 show the average cost of accident benefits claims in the 1977 to 1986 period. The blue bars in Figure 7.1 adjust the accident benefit average claims costs to 1981 dollars. Figure 7.2 shows the accident benefits pure premium calculation, which is the cost of accident benefits claims by vehicle insured.

Figures 7.3 and 7.4 show the average claims costs for collision and the collision pure premium calculation. Both current and 1981 dollars are shown. Figures 7.5 and 7.6 provide the same information, but with respect to comprehensive coverage.[7]

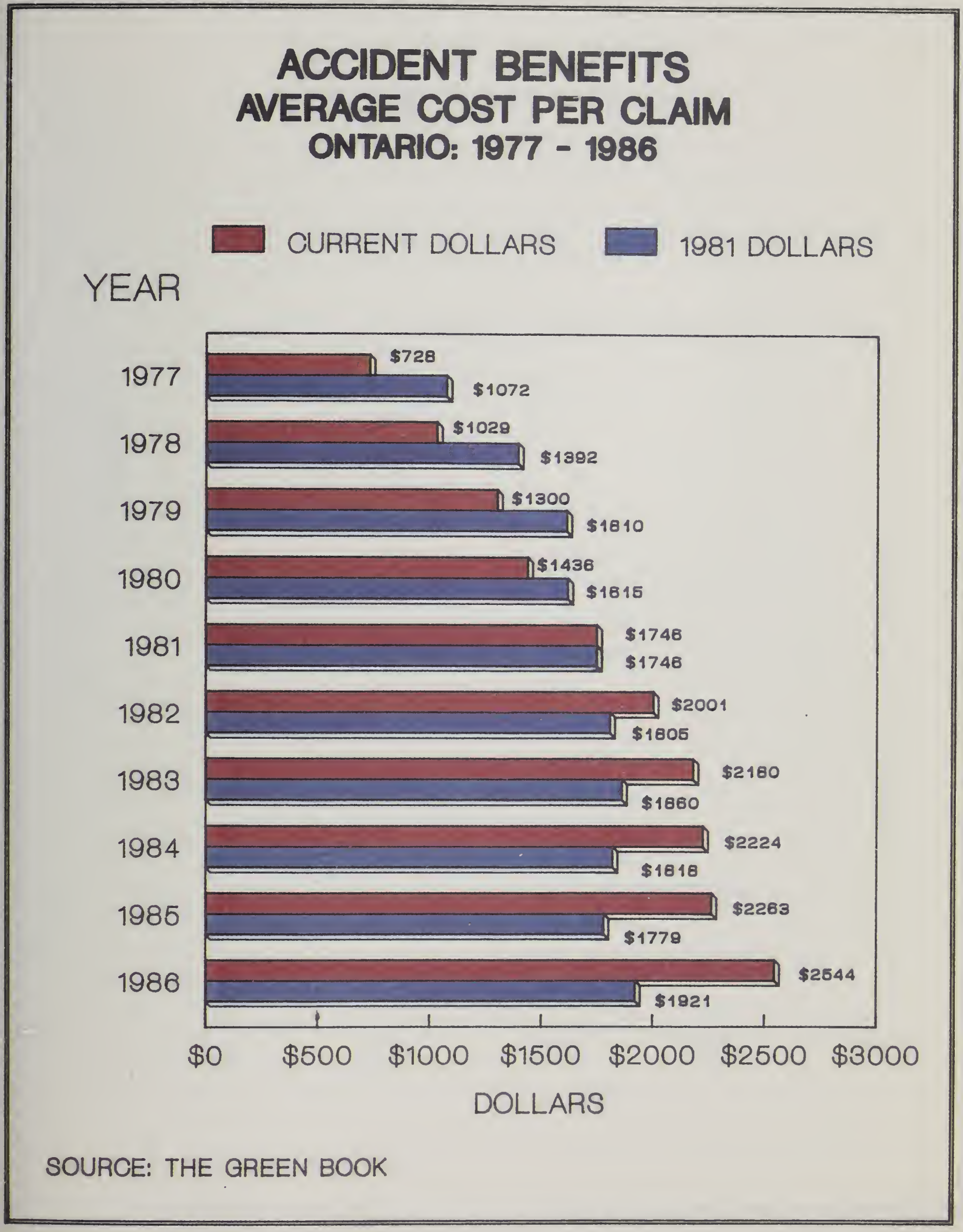
The property damage component of the Section A liability coverage mainly relates to vehicle damage. There is no doubt that vehicle damage claims are costly; as Table 7.2 shows, property damage losses in 1986 exceeded $300 million. The adjusted property damage loss cost per car has remained relatively stable. Accident benefits loss costs have increased, but seem to be under control. The available evidence suggests that the loss costs problem area is in bodily injury claims; therefore, it is useful to consider what the constituent parts of those loss costs are.

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[6] This is Section B of the policy, the so-called no fault benefits section. Section B coverage is compulsory.

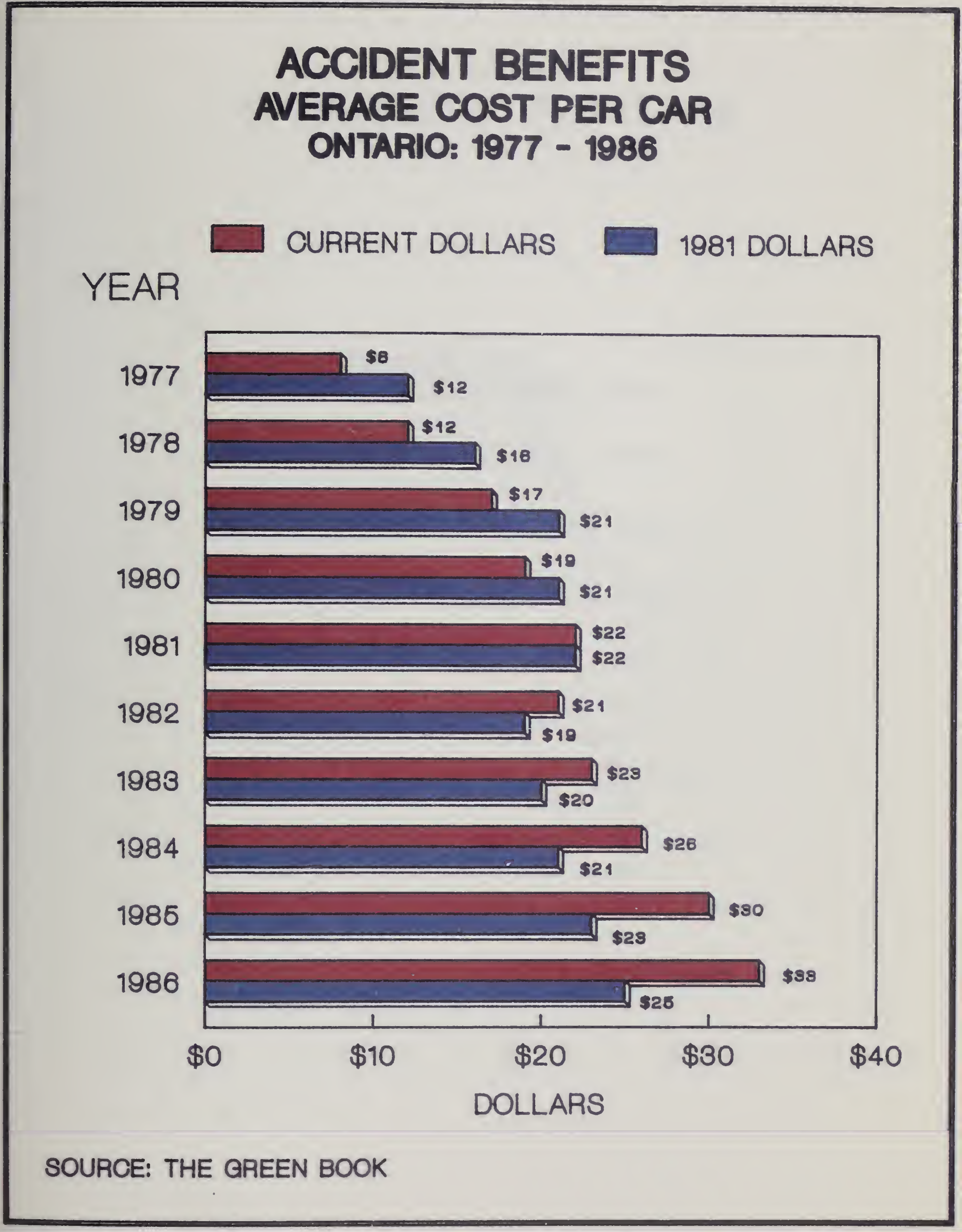
[7] Collision coverage is contained in Section C of the standard automobile policy. Section C coverage is not compulsory; there are fewer cars insured for Section C collision or comprehensive coverage than for bodily injury property damage and accident benefits coverage.

Figure 7.1



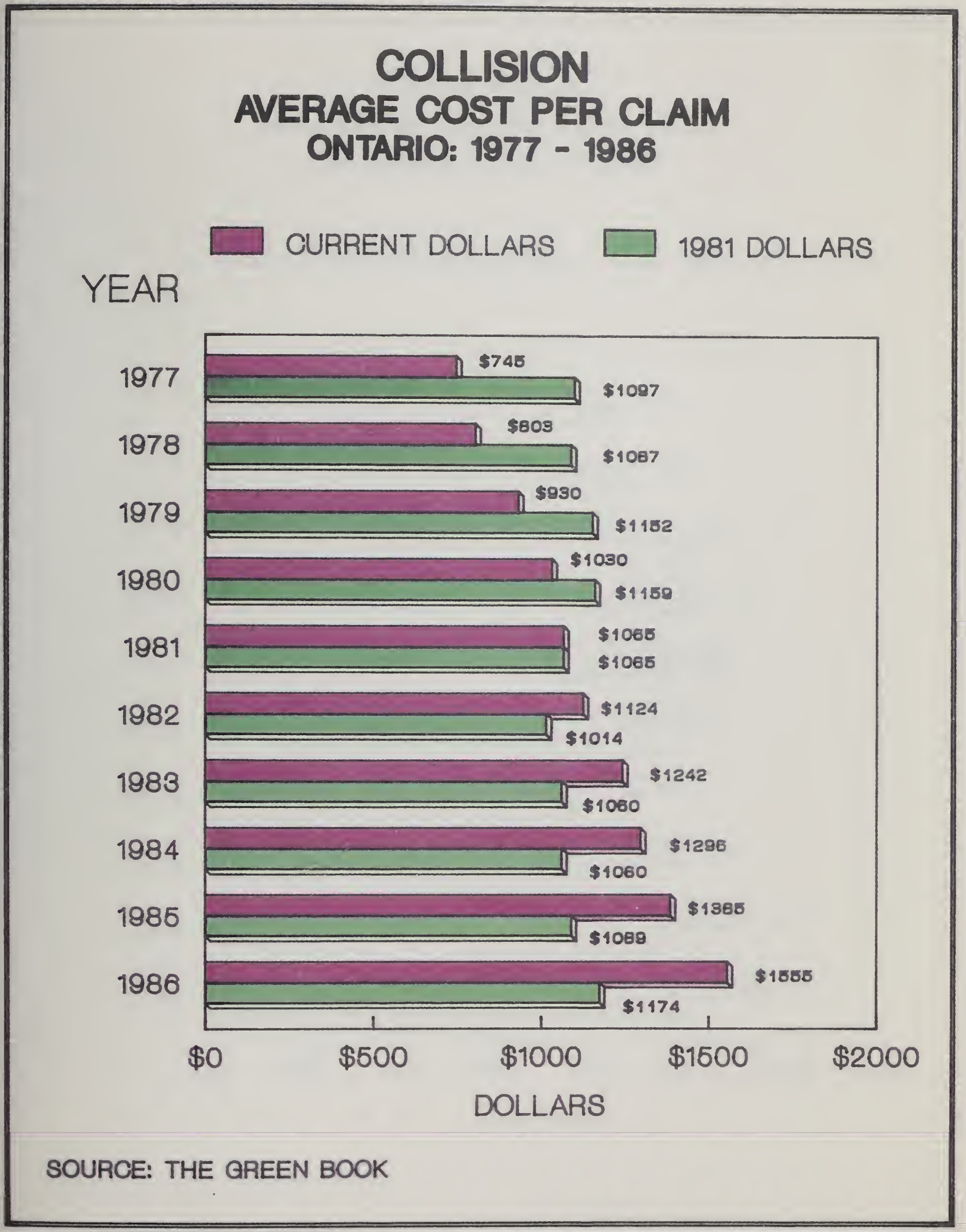
SOURCE: THE GREEN BOOK

Figure 7.2



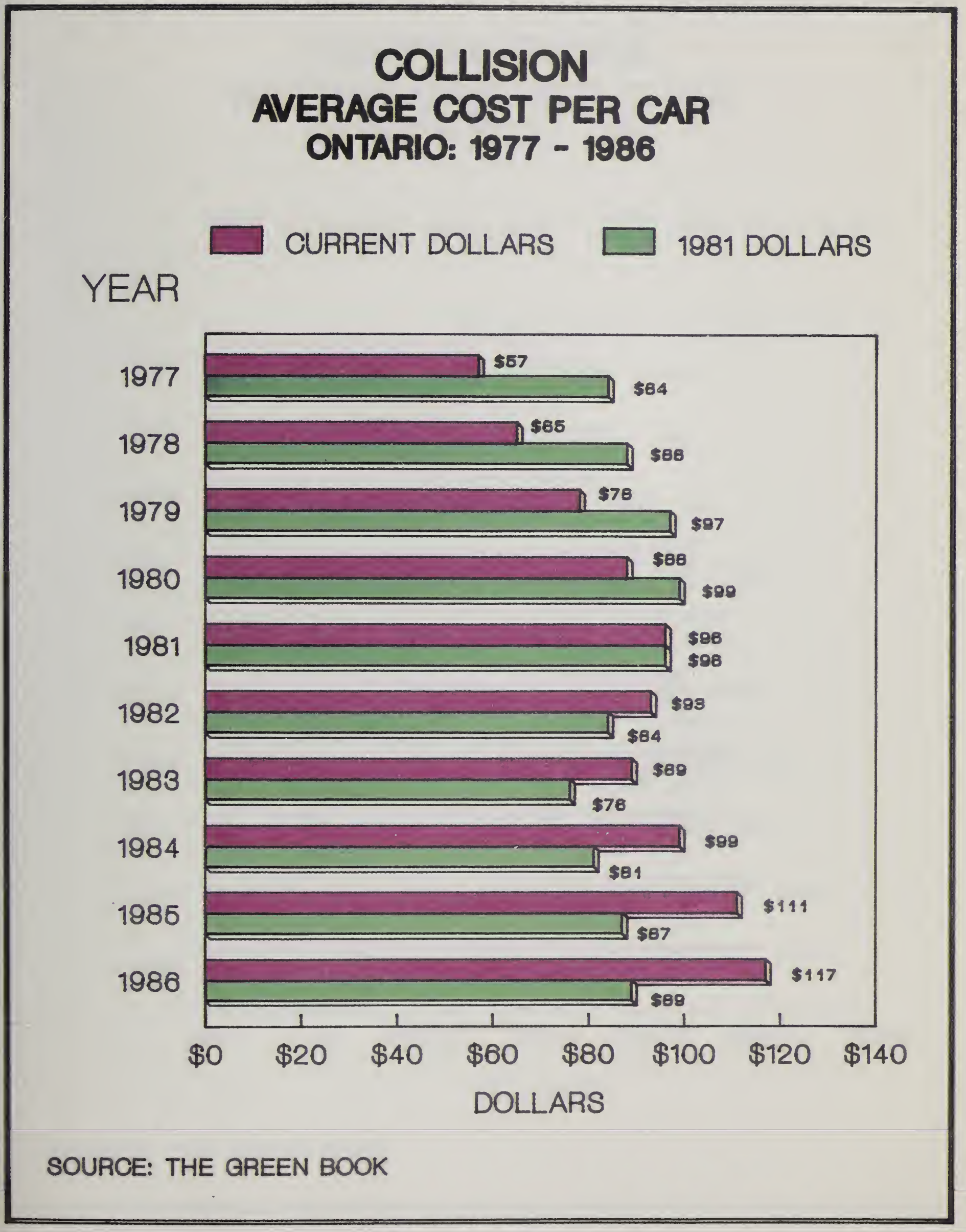
SOURCE: THE GREEN BOOK

Figure 7.3



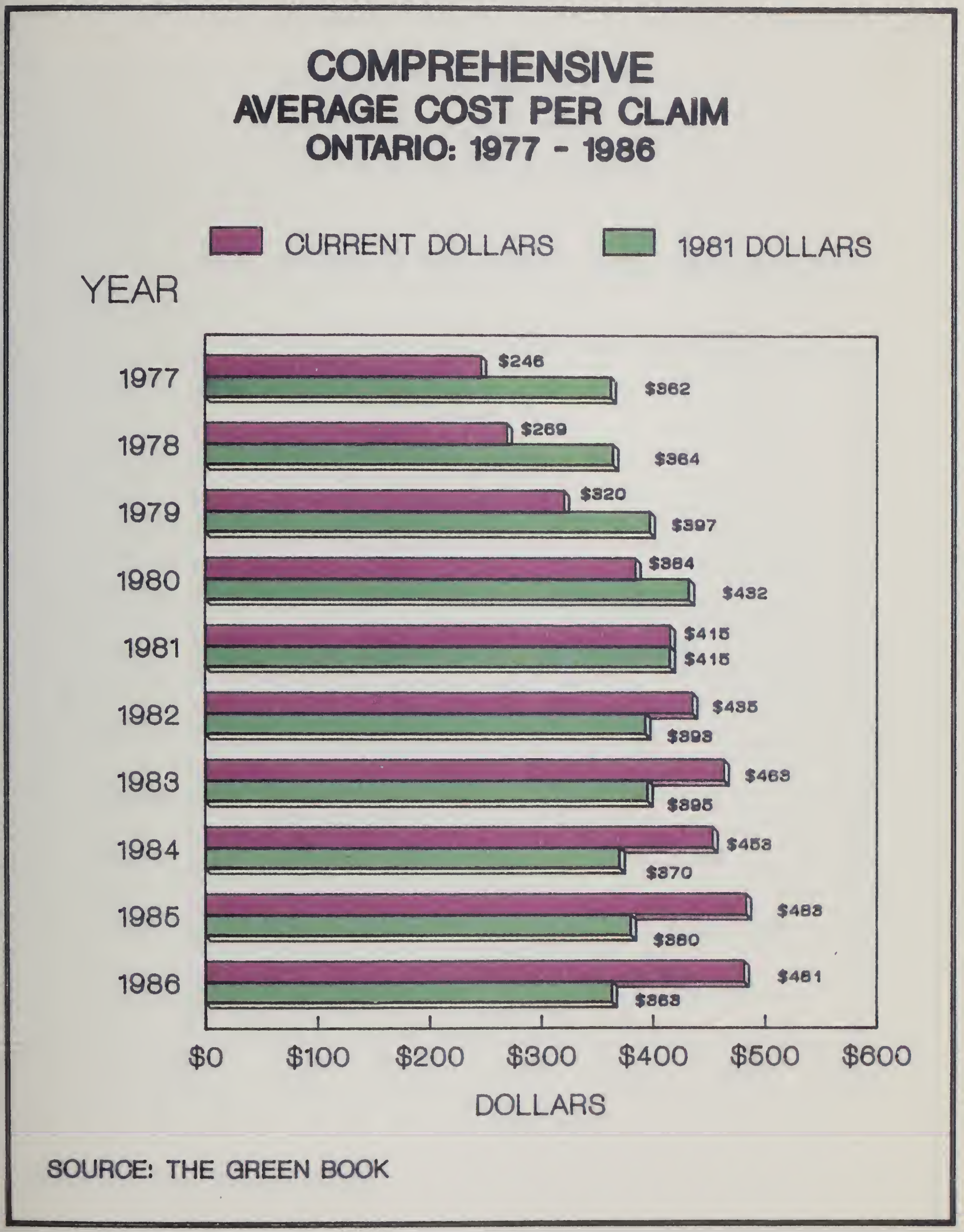
SOURCE: THE GREEN BOOK

Figure 7.4



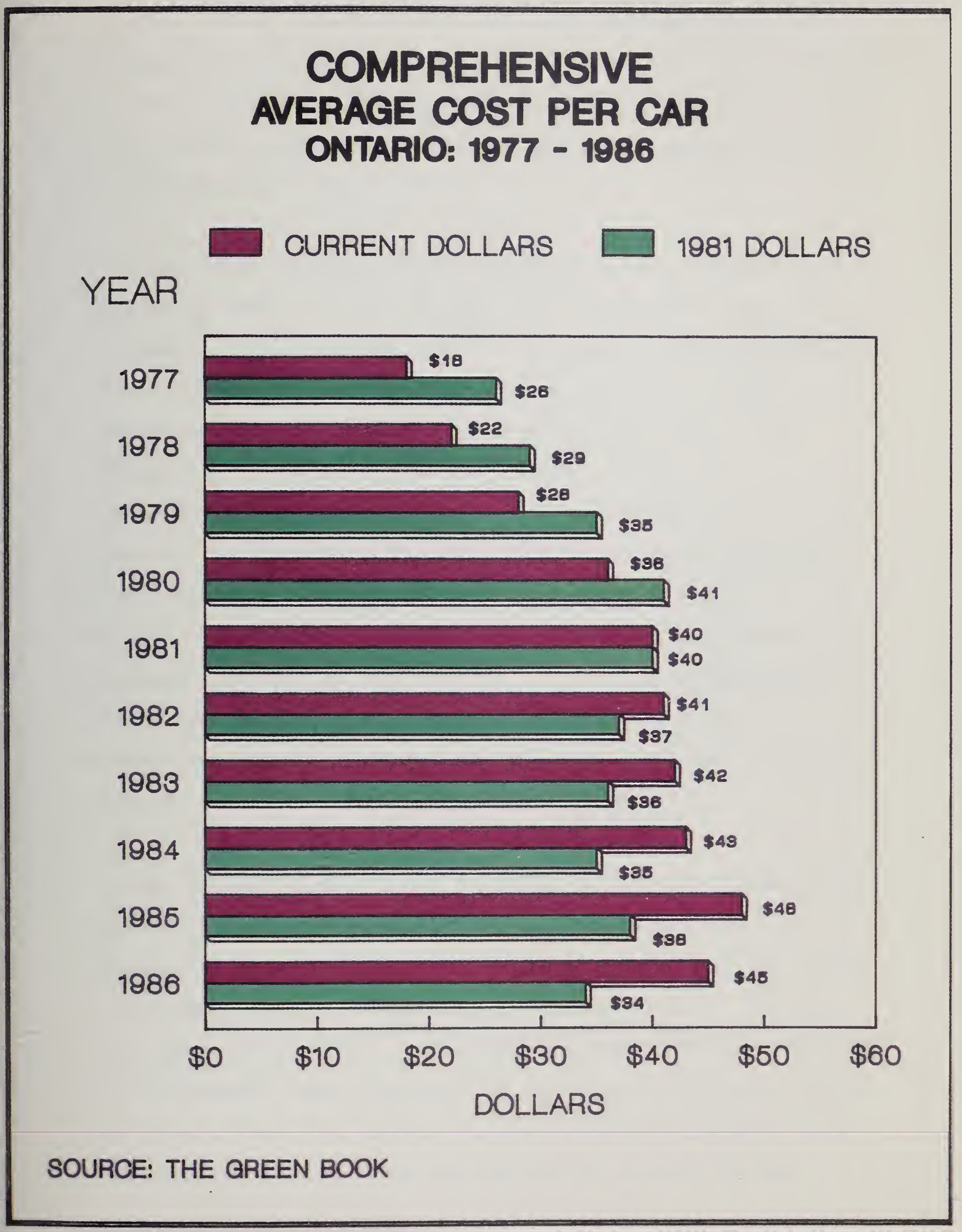
SOURCE: THE GREEN BOOK

Figure 7.5



SOURCE: THE GREEN BOOK

Figure 7.6



SOURCE: THE GREEN BOOK

Two bodily injury claims surveys undertaken by this Inquiry have developed reliable evidence as to the anatomy of bodily injury claims. Because the claims surveys dealt with closed claims, the issue of reserves did not have to be considered.[8]

The first claims survey analyzed 1,594 claims files closed in 1986 in which almost $22 million was paid to claimants. For reasons more fully developed in Appendix III, I am satisfied that the claims survey data and the conclusions to be drawn from them are reliable. The judgment or settlement bodily injury claims cost breakdown as set out in Figure 7.7 was calculated on the basis of all surveyed claims. The proportions changed when claims of specific sizes were assessed. Figure 7.8 shows the breakdown for claims resolved by settlement or judgment between $1 and $10,000. Figure 7.9 represents the breakdown for claims resolved by judgment or settlement between $10,001 and $75,000. Figure 7.10 is a similar breakdown for claims over $75,000.

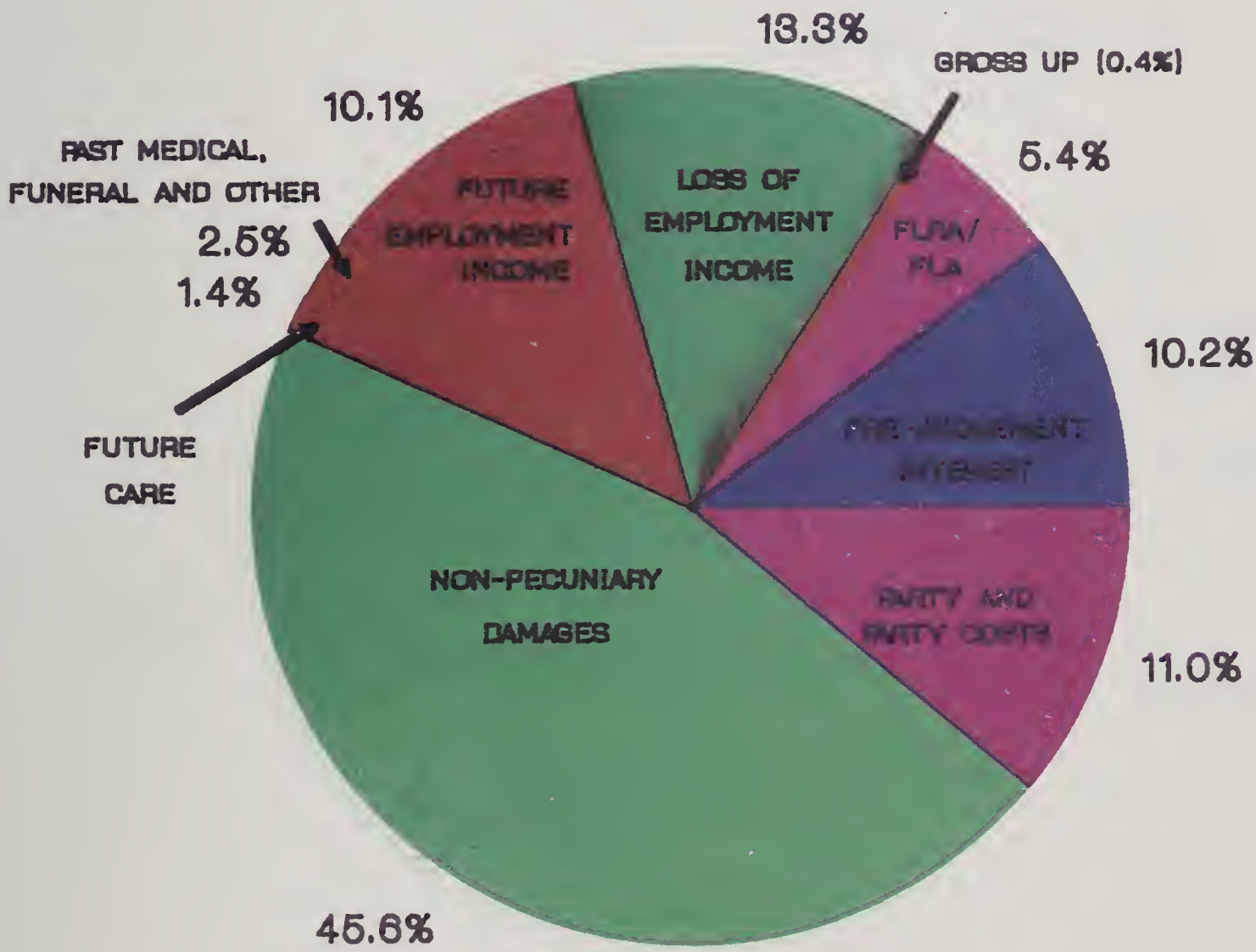
The second bodily injury claims survey was undertaken specifically to collect data as to the impact of the collateral source rule. It was also undertaken to verify the claims results of the first claims survey. Because insurers cannot deduct collateral source payments received by a claimant, the payments are often not recorded, with the result that the impact of the collateral source rule remained uncertain. The second bodily injury claims

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[8] For an explanation of the structure and reliability of the bodily injury claims survey, see Appendix III.

Figure 7.7

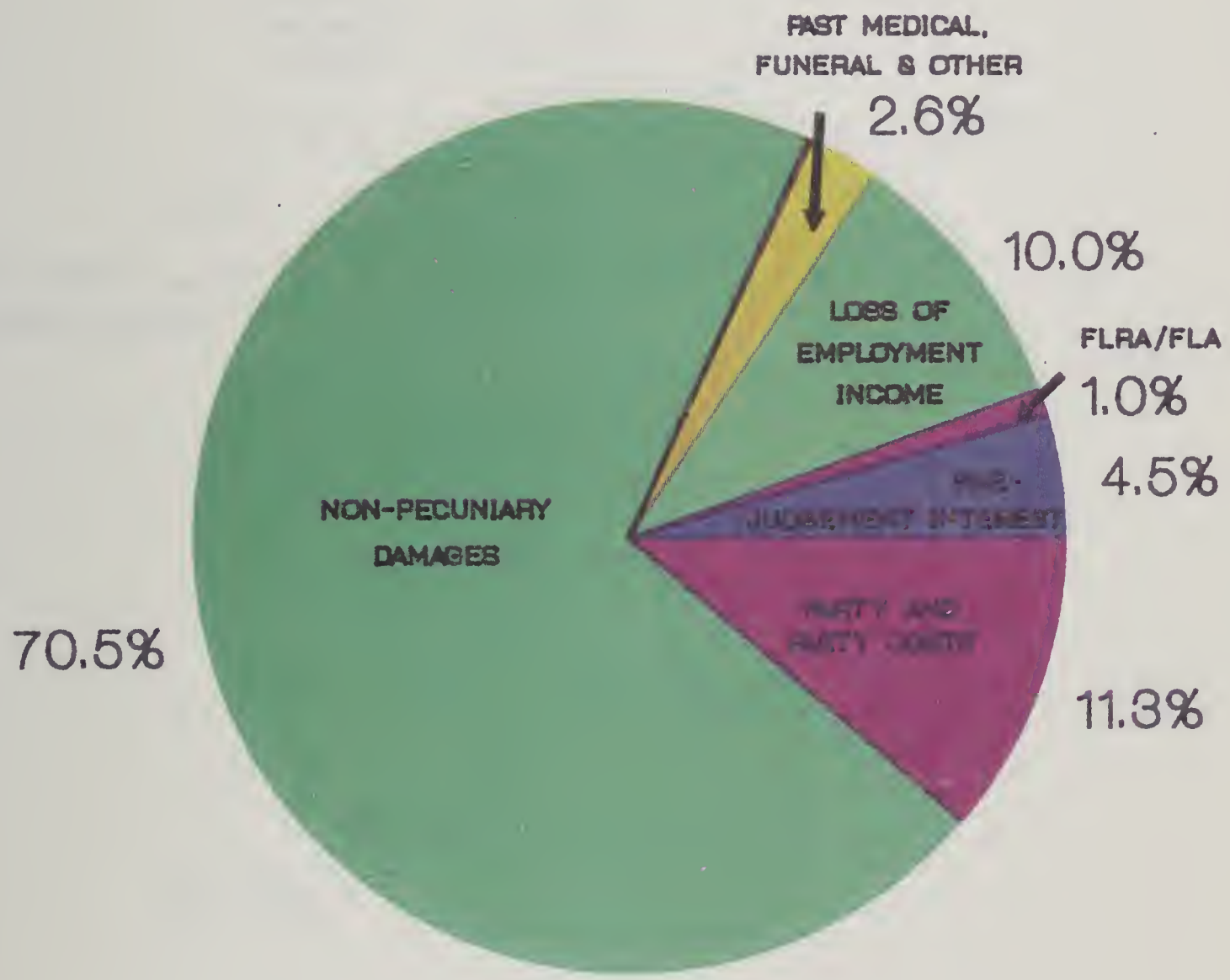
BREAKDOWN OF JUDGEMENT/SETTLEMENT
BODILY INJURY CLAIMS: ALL CLAIMS
ONTARIO: 1986



SOURCE: CLAIMS INFORMATION SURVEY

Figure 7.8

BREAKDOWN OF JUDGEMENT/SETTLEMENT
BODILY INJURY CLAIMS: $1 TO $10,000
ONTARIO: 1986



SOURCE: CLAIMS INFORMATION SURVEY

Figure 7.9

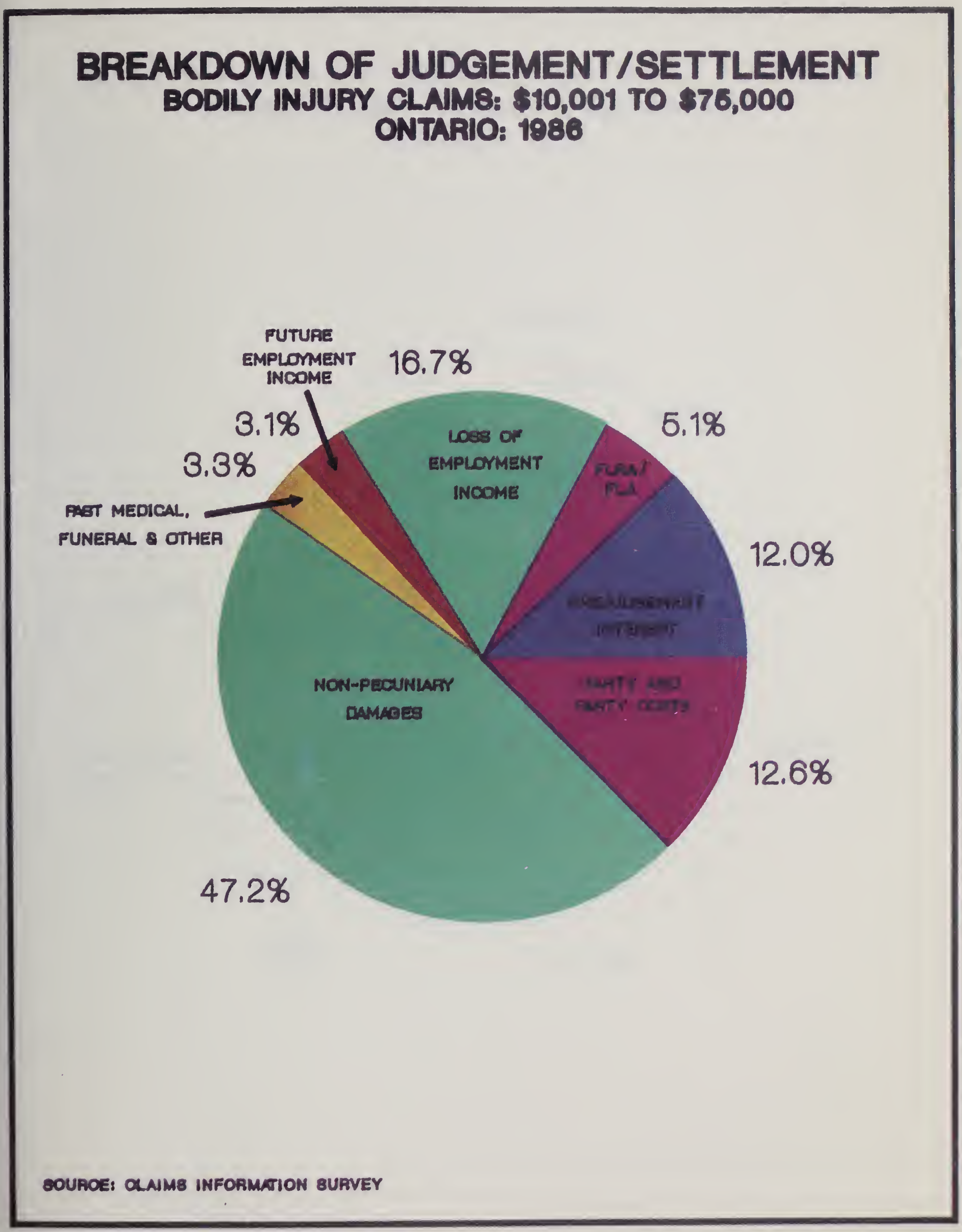
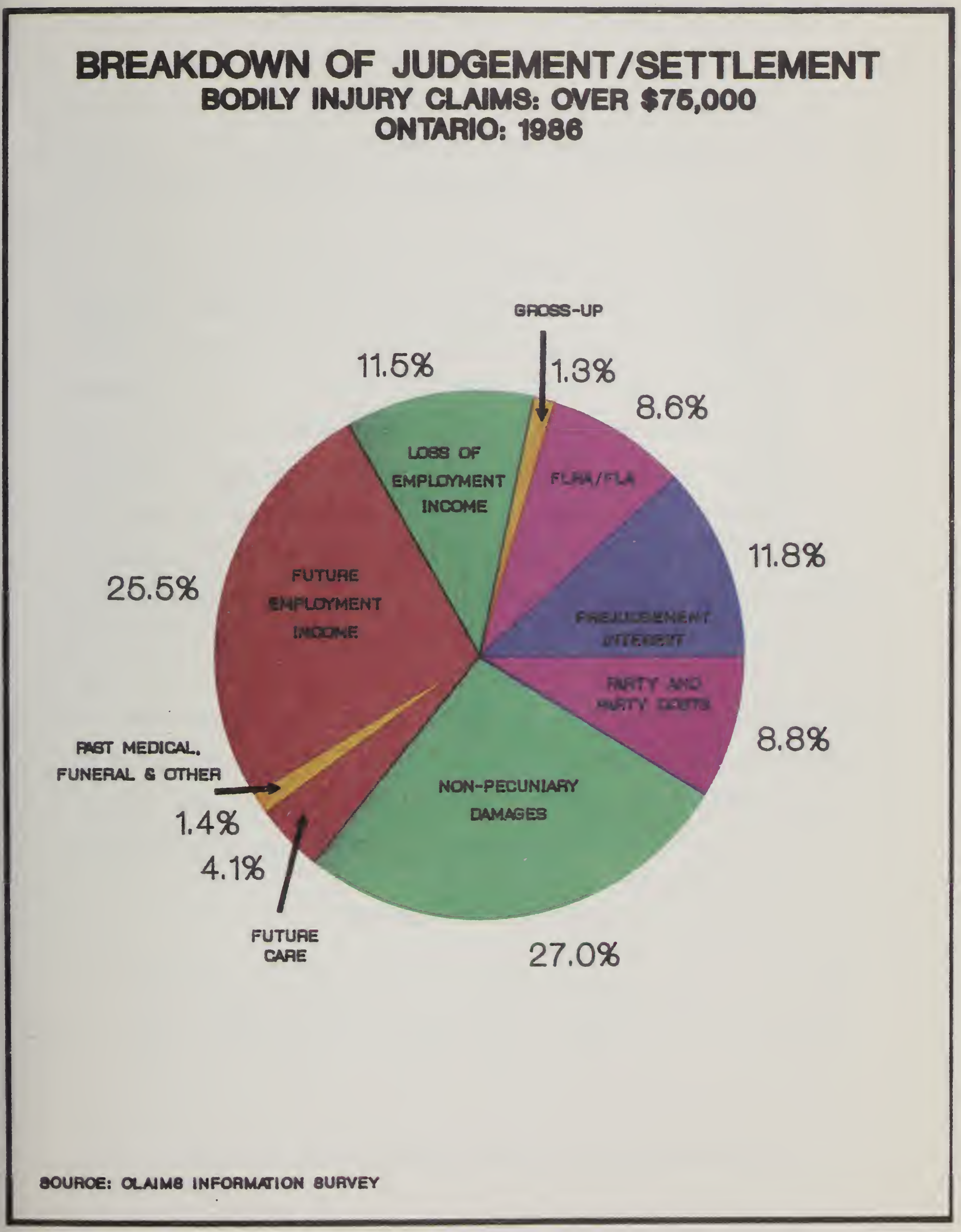

BREAKDOWN OF JUDGEMENT/SETTLEMENT
BODILY INJURY CLAIMS: $10,001 TO $75,000
ONTARIO: 1986
FUTURE EMPLOYMENT INCOME
16.7%
3.1%
3.3%
PAST MEDICAL, FUNERAL & OTHER
LOSS OF EMPLOYMENT INCOME
5.1%
12.0%
NON-PECUNIARY DAMAGES
47.2%
12.6%
SOURCE: CLAIMS INFORMATION SURVEY

Figure 7.10


BREAKDOWN OF JUDGEMENT/SETTLEMENT
BODILY INJURY CLAIMS: OVER $75,000
ONTARIO: 1986
GROSS-UP
1.3%
11.5%
8.6%
LOSS OF EMPLOYMENT INCOME
FLRA/FLA
11.8%
25.5%
FUTURE EMPLOYMENT INCOME
PREJUDGEMENT INTEREST
PARTY AND PARTY COSTS
8.8%
PAST MEDICAL, FUNERAL & OTHER
1.4%
NON-PECUNIARY DAMAGES
4.1%
FUTURE CARE
27.0%
SOURCE: CLAIMS INFORMATION SURVEY

survey required insurers to record a complete breakdown of all claims over $5,000 as those claims were being closed by settlement or trial over a six-week predetermined period in 1987. Where files did not contain collateral source information, insurers were asked to get it. All of the insurers involved cooperated.[9]

As shown in Figures 7.7 through 7.10, non-pecuniary general damages (pain and suffering, loss of enjoyment of life) represent the single most significant segment of damages, at all levels. It is clear that as the size of the claim increases, the proportion of non-pecuniary general damages decreases. In smaller claims (claims between $1 and $10,000) non-pecuniary general damages consume 70.5¢ of the claims settlement dollar. For claims above $75,000 non-pecuniary general damages account for 25.5¢ of the claims settlement dollar.

The impact on claims costs of prejudgment interest and F.L.R.A./F.L.A. claims is clear. The first Inquiry bodily injury claims survey shows the prejudgment interest and F.L.R.A./F.L.A. breakdown as follows:

Prejudgment Interest

(a) all claims surveyed (Fig. 7.7)	10.2%[10]
(b) claims between $1 & $10,000 (Fig. 7.8)	4.5%
(c) claims between $10,001 & $75,000 (Fig.7.9)	12.0%
(d) claims over $75,000 (Fig. 7.10)	11.8%

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[9]The results of this second survey are considered in Chapter 10.

[10]This is a composite total which includes all those claims referred to in (b), (c) and (d).

Family Law Reform Act/Family Law Act

(a) all claims surveyed (Fig. 7.7)	5.4%
(b) claims between $1 & $10,000 (Fig. 7.8)	1.0%
(c) claims between $10,001 & $75,000 (Fig. 7.9)	5.1%
(d) claims over $75,000 (Fig. 7.10)	8.6%

Party-and-party costs paid to counsel for the injured claimants account for 11.0% of the claims dollar. For smaller claims between $1.00 and $10,000, costs account for 11.3% of the settlement dollar. This rises to 12.6% for claims between $10,000 and $75,000 and declines to 8.8% for claims above $75,000. When lawyers are involved in smaller claims, insurers will frequently pay up to 15% of the settlement in costs to the claimant's lawyer. An additional amount for disbursements is often paid as well. The 11.3% cost figure for claims between $1.00 and $10,000 is explained by the high percentage cost factor used, particularly in smaller claims, as modified by the relatively high number of smaller cases disposed of without a lawyer being involved. Involvement of lawyers per claim is higher for larger cases.[11] For cases over $75,000, insurers do not routinely pay 15% in costs but that goes to explain why the party-and-party costs seem to be proportionately lower for claims above $75,000 than for claims between $10,000 and $75,000.

Figures 7.7, 7.8, 7.9 and 7.10 do not refer to defence legal costs. The claims survey was intended to focus on compensation actually paid to injured persons, quite apart from the consideration of costs incurred by insurers in

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[11] For cases above $25,000, all claimants had a lawyer.

adjusting and defending claims. Those costs will be considered separately as part of transaction costs.[12]

The I.B.C. undertook its own claims study in February 1987.[13] The I.B.C. claims survey involved 1,144 claims. Of those claims, 391 were closed with a payment of more than $90,000. 753 claims were closed with a payment of between $25,000 and $90,000. The I.B.C. sampling did not take smaller losses (below $25,000) into account. Figures 7.11, 7.12 and 7.13 provide a breakdown of judgments and settlements according to the I.B.C. claims survey.[14] I do not know why the I.B.C. survey ignored claims below $25,000 and tended to emphasize claims over $90,000. The I.B.C. survey included defence legal costs. To permit a proper comparison with Inquiry claims data, those costs have been factored out. Overall, the data from the Inquiry survey and the I.B.C. survey are generally consistent. This is particularly true for the larger claims.

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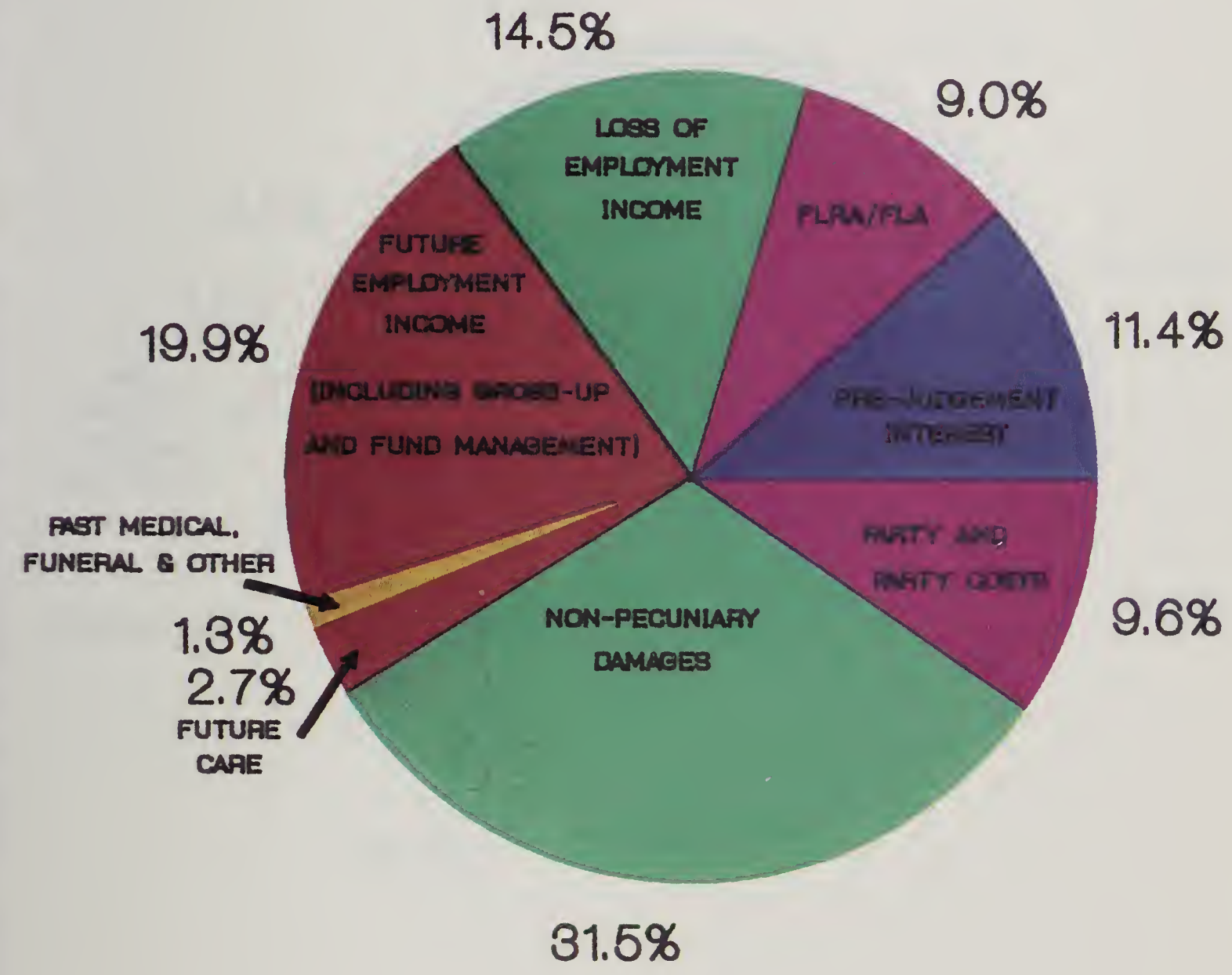
[12] Transaction costs refer to any expenditures undertaken to process a claim. They include party-and-party costs paid to claimants, defence legal costs, internal and external adjusting costs, the cost of other experts, and other claims-related expenses. See Inquiry Claims Survey, Appendix III.

[13] See I.B.C. claims survey (February 1987), Appendix XVII.

[14] The I.B.C. claims survey considered claims closed in 1985 and 1986. The accident dates extended through 1981 to 1983. A 40:60 waiting scheme was imposed, based on the 1983 fiscal policy year, size of bodily injury loss distribution (private passenger motor vehicles excluding farmers). This distribution shows that claims over $25,000 made up approximately 65% of bodily injury losses.

Figure 7.11

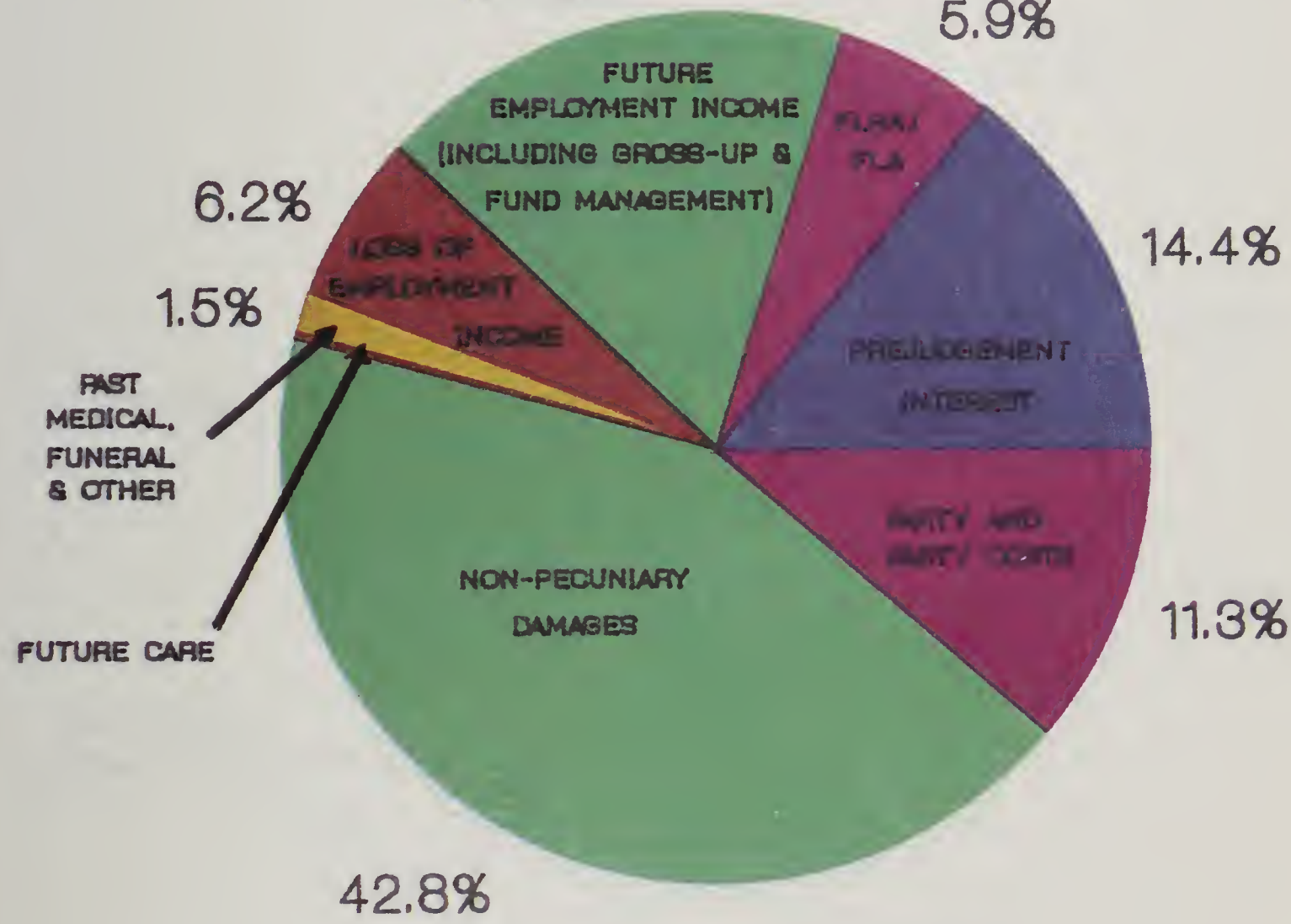
BREAKDOWN OF JUDGEMENT/SETTLE BODILY INJURY CLAIMS: COMPOSITE ONTARIO: 1981 - 1983



SOURCE: IBC CLAIMS SURVEY

Figure 7.12

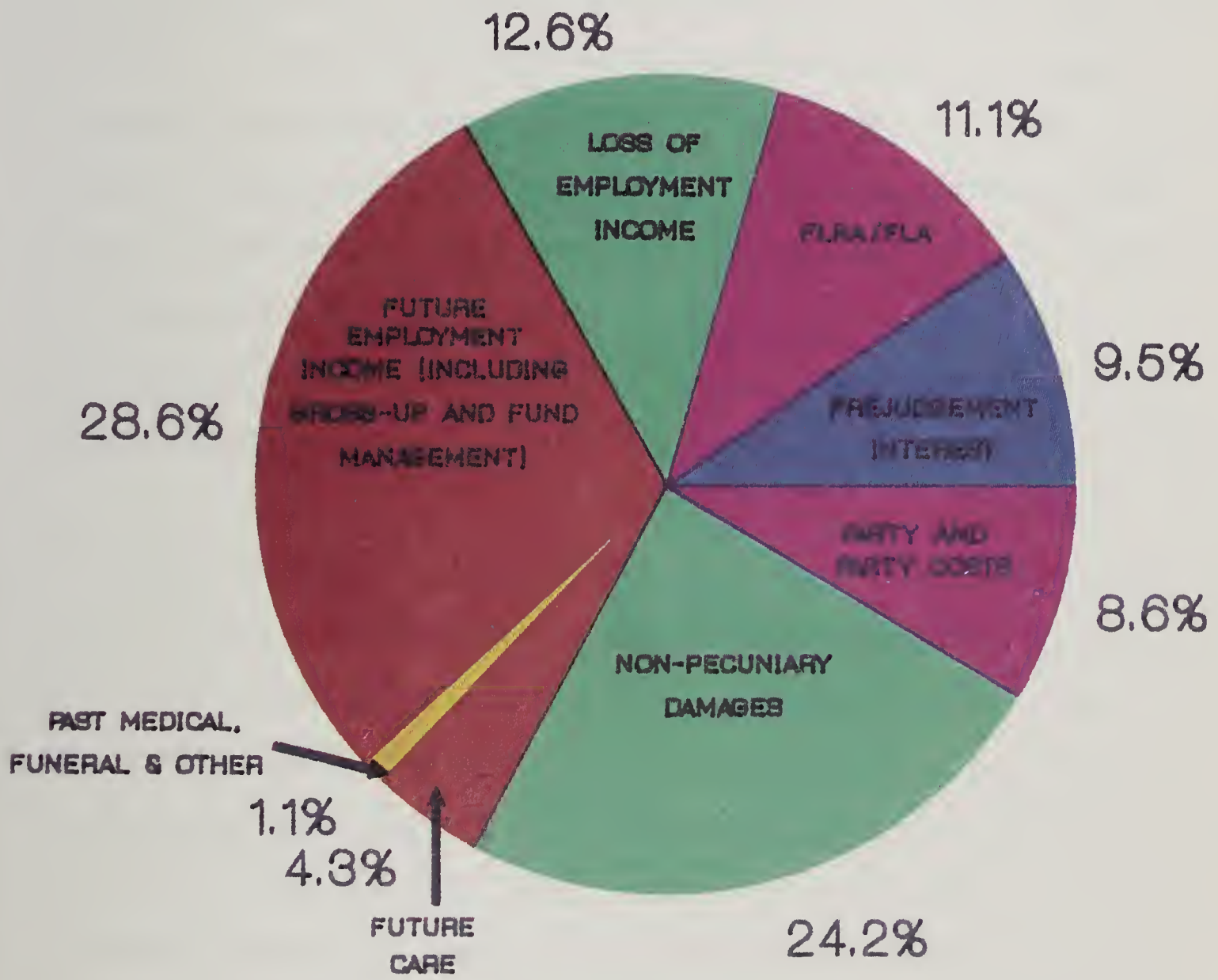
BREAKDOWN OF JUDGEMENT/SETTLEMENT
BODILY INJURY CLAIMS:$25,000 to $90,000
ONTARIO:1981 - 1983



SOURCE: IBC CLAIMS SURVEY: Using Claims settled during 1985-1986 for accidents which occurred between 1981 and 1983

Figure 7.13

BREAKDOWN OF JUDGEMENT/SETTLEMENT
BODILY INJURY CLAIMS: OVER $90,000
ONTARIO: 1981 - 1983



SOURCE: IBC CLAIMS SURVEY:

I have not dealt with claims adjustment expenses, except for the brief reference made to defence legal costs. When insurers refer to claims costs or loss costs, the reference includes claims actually paid, claims adjustment expense paid, reserves established for unpaid but reported claims and reserves established for claims incurred but not reported (I.B.N.R. reserves). If a claim is paid, the claims cost will include claims adjustment expense; if a claim is pending, the file reserve established will include an estimate of claims adjustment expense. For now, I think it is reasonable to ignore transaction costs expended in resolution of third party bodily injury claims, subject to the observation that those costs have remained relatively stable. The increase in gross payout for bodily injury claims is not attributable to any significant increase in transaction costs, except possibly as related to defence legal costs.

Knowing what claims costs are, how they break down and that bodily injury costs have increased does not tell us why bodily injury claims costs have increased. Some have suggested that prejudgment interest and F.L.R.A./F.L.A. claims are the culprits.[15] Both prejudgment interest and F.L.R.A. claims have been with us since 1978. There is no doubt that the impact of prejudgment interest and the F.L.R.A. was not felt immediately. While F.L.R.A./F.L.A. claims and prejudgment interest have undoubtedly contributed to the steady increase in bodily injury claims

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[15] For claims over $75,000, 25.2% of the dollars paid is attributable to prejudgment interest and F.L.R.A./F.L.A. claims. The cumulative total of prejudgment interest and F.L.R.A./F.L.A. claims is about the same for claims between $25,001 and $75,000, and all claims.

costs, to isolate F.L.R.A./F.L.A. claims and prejudgment interest as the root cause of increased bodily injury claims costs is a mistake and results in other cost factors being ignored. If anything, recent decisions of the Ontario Court of Appeal have resulted in F.L.R.A./F.L.A. claims being reduced. There is no single factor which has dominated in driving bodily injury claims costs up. In my view, there are a number of explanations. They include:

1. Economic loss increases in times of economic prosperity. Ontario has been economically prosperous since 1983-1984. More injured claimants have been employed and employed at higher wage rates. There are relatively fewer homemakers and more wage earners than was the case in the early 1980s. Accidents that once might have involved persons not in the labour force now involve injured persons with substantial claims for past and future loss of income. Economic prosperity has led to increased economic loss following a motor vehicle accident.

2. Economic prosperity leads to more driving, and some suggest, more driving at high risk times. As traffic density increases, accident frequency increases.

3. Since 1980, the discount rate has been established by statute at 2-1/2%. In 1978, a 7% discount rate was commonly used.[16]

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[16] This was the discount rate used in the Trilogy. The 2-1/2% discount rate has a significant effect in increasing damages in larger cases where funds have to be established at the time of settlement or trial to take care of future losses.

4. The Supreme Court of Canada's decisions in the Trilogy in 1978,[17] have forced trial judges and juries to break down damage assessments into reasonable constituent parts. This breakdown has resulted in a higher calculation of economic loss. Trial judges and juries can no longer rationalize their way to a decision by establishing an amount that sounds right. This has increased damages in many claims, particularly large claims.

5. Injured claimants have increasingly retained counsel to represent their interests. The Inquiry Claims Survey reveals that the use of counsel by injured claimants varies from region to region. On a province-wide basis, 57.6% of claimants were represented by counsel. In Toronto claims, 63.1% of claimants were represented by counsel. In cases above $25,000, all claimants were represented by counsel. Claimants' use of counsel is higher in urban areas and lower in rural areas.[18] On an aggregate basis it seems that the use of counsel has increased on a province-wide basis; that increase has led to a direct increase in claims costs. Once a claimant retains counsel, the insurer is required in almost all cases to pay an additional 10 to 15% to that counsel in party-and-party costs. That is a direct cost

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[17]The Trilogy consists of Andrews v. Grand & Toy Alberta Ltd., [1978] 2 S.C.R. 229; Arnold v. Teno, [1978] 2 S.C.R. 287; Thornton v. Prince George School District, [1978] 2 S.C.R. 267.

[18]See Appendix III.

increase. There are ripple effects as well. Counsel will almost invariably secure payment of prejudgment interest, which might not otherwise be paid. Further, the involvement of counsel, on balance, will result in an increase in the settlement value of the claim. There is no doubt that for similar injuries, claimants represented by counsel secure more compensation than those claimants that are not represented by counsel.

6. One of the indirect consequences of the Trilogy was the development of expertise among lawyers in establishing economic loss. Although I have no data to support this conclusion, it seems to me that lawyers are increasingly inventive in their development of evidence to establish economic loss. This inventiveness leads to increased economic loss damage assessments.

7. In my view, doctors, economists, actuaries and other experts are more capable of giving evidence in a manner that is convincing to trial courts. This, of course, cuts both ways as experts appear for both plaintiffs and defendants, but on balance results in an increase in damages. When trial damages increase, settlements tend to increase. Experts have become more proficient in preparing reports required for personal injury litigation. Those reports have an impact in establishing damages for trial or settlement purposes. As well, expert reports are expensive and in the final analysis are usually paid for by the defendant's insurer as part of party-and-party costs.

8. Gross-up is now a fact of life in larger claims. The Inquiry Claims Survey showed gross-up at 0.4% of

claims costs, but this is misleading. There was not a sufficient number of large cases in which gross-up was a factor to permit a realistic consideration of the actual impact of the gross-up on damage and settlement assessments. Moreover, because of gross-up, among other things, larger cases involving significant future care costs are often resolved by the use of structured settlements. In those cases where future care costs are significant, or in major fatal accident cases, gross-up significantly increases claims costs.

9. Health care advances have resulted in badly injured persons surviving at great expense over a significant, albeit reduced, life expectancy. In such cases, future care costs can be enormous. Health care advances in areas such as prosthetic devices have resulted in significant cost increases.[19]

10. In my opinion, pre-trials have resulted in higher costs in claims which have gone to pre-trial and in cases which are indirectly influenced by the results of pre-trials in other cases. Every litigated motor vehicle negligence case is pre-tried if it is not resolved by settlement at an earlier stage. Although most cases are resolved by settlement before a pre-trial, I think the pre-trial process generally works to increase the value of claims. Through the mechanics of a pre-trial, areas of deficiency in the plaintiff's case are often identified and, I assume, corrected. Subsequent assessments of damages tend to

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[19] Gianonne v. Weinberg, unreported decision of Fitzpatrick J., Ont. H.C., May 22, 1986.

be based upon that information. It used to be thought that juries established reasonable bases for the judicial assessment of non-pecuniary general damages. I have never subscribed to that view. It was then thought that judges, through their judgments in cases which were not settled, established what should be paid in typical injury cases. There was a certain legitimacy to that contention given the propensity of judges and lawyers to seek guidance from decided cases. I am convinced that the pre-trial now establishes the going rate, particularly for non-pecuniary loss, because pre-trial judges are made aware of what is being offered and paid for non-economic loss in the real world. Subsequent assessments of damages are influenced by that process.

11. There is no doubt that F.L.R.A./F.L.A. claims have increased damages. The increase has been substantial; however, as F.L.R.A. claims have existed since 1978, I do not think recent increases in bodily injury claims costs can be attributed to the F.L.R.A. or the F.L.A.

12. Prejudgment interest is a real cost to the compensation system. Prejudgment interest has been a part of the system since late 1977 and its impact is significant. The settlement of serious bodily injury claims is often delayed. The high interest rates of the early 1980s undoubtedly increased claims costs even if on settlement or at trial interest rates were averaged. It is unusual to find a case in which the claimant is represented by a lawyer where prejudgment interest is not paid.

13. Judicial generosity is another issue to be considered. I confess to a bias on this issue. Judges (and to a lesser extent juries) are often criticized for unreasonably high awards. I do not think that the assessment of non-pecuniary loss has dramatically increased. In catastrophic cases, non-pecuniary losses are capped at approximately $200,000 (1987 dollars). Although non-pecuniary damage assessments have increased in smaller cases, when inflation is considered, the increase has not been substantial. For example, in 1960, a soft tissue, non-serious neck injury (the so-called whiplash injury) was worth approximately $1,500 for non-pecuniary general damages. The value of that kind of injury gradually increased, first to approximately $3,000, and then to $5,000. I am told that such an injury is now worth between $6,000 and $8,000. That appears to be a dramatic increase in value for a less than dramatic injury; however, if a 1960 $1,500 injury is adjusted to inflation, it should be assessed at $6,250 in 1987. An analysis of Inquiry Claims Survey data reinforces the conclusion referred to above. Those data suggest that the weighted average (cars, trucks and motorcycles) of the non-pecuniary general damages paid for soft tissue neck injuries is $7,558.46. In contrast to products liability and occupiers' liability cases, insurers have not suggested that judges have expanded the perimeters of negligence in motor vehicle accident litigation. Judicial generosity is overplayed by insurers. The Court of Appeal has consistently reduced inordinately high damage assessments; there is, however, no doubt that economic loss has increased and the judicial treatment of it has been more generous particularly in the case

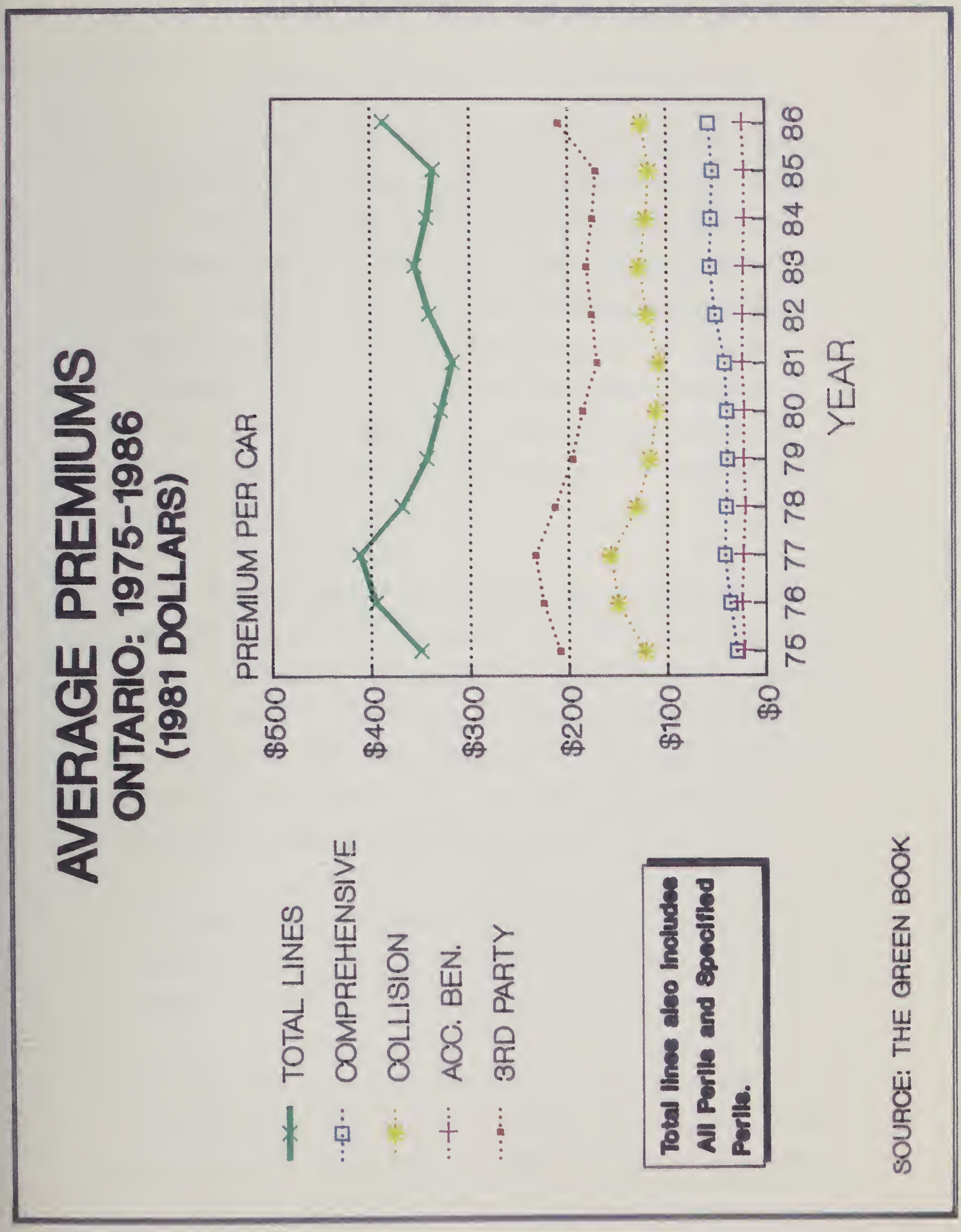
of future care costs. This has increased bodily injury costs. In my view, that is the way it should be. The catalyst for a more humane response to future care costs was provided by the Supreme Court of Canada's judgment in Andrews. Finally, apart from the Court of Appeal's influence, it seems to me that in the last few years trial judges and juries have become more moderate in their treatment of non-pecuniary compensation. This is particularly visible in Family Law Act claims. Many insurers have acknowledged this trend.

B. PREMIUMS

It is useful to consider past premium trends for all coverages in two general respects. First, quite apart from loss costs, increases and decreases in automobile insurance premiums should be viewed over a reasonable period of time and measured in constant dollars. Second, the historic relationship between loss costs and premiums has to be taken into account to the extent that insurers have regard to past loss cost experience in predicting future loss costs. I, therefore, propose to examine the trends for premiums and loss costs for Sections A, B and C of the automobile policy and on a composite basis for the period 1975 to 1986.

Figure 7.14 sets out the premium trends for Sections A, B and C (collision and comprehensive only) of the automobile policy. Figure 7.14 also presents a composite

Figure 7.14


AVERAGE PREMIUMS
ONTARIO: 1975–1986
(1981 DOLLARS)
PREMIUM PER CAR
$500
$400
$300
$200
$100
$0
75 76 77 78 79 80 81 82 83 84 85 86
YEAR
TOTAL LINES
COMPREHENSIVE
COLLISION
ACC. BEN.
3RD PARTY
Total lines also includes All Perils and Specified Perils.
SOURCE: THE GREEN BOOK

premium line as indicated.[20] All premiums are measured in constant (1981) dollars. These general conclusions are evident:

(a) Although third party liability/property damage (Section A) premiums increased substantially in 1985 and 1986, the 1986 level was still less than the premium level in 1977. It should be noted that there was a steady and relatively substantial premium decrease from 1977 when premiums were at their highest, to 1981. Section A premiums remained relatively stable between 1981 and 1985 when, as indicated, third party premiums were substantially increased.

(b) The accident benefit (Section B) premium line has been relatively unstable but the variations from year to year have not been as dramatic as for Section A premiums. In constant dollars accident benefit premiums in 1986 were marginally lower than accident benefit premiums in 1976 and about the same as accident benefit premiums in 1981.

(c) Section C collision premiums in 1986 were substantially lower than their high point in 1977 and about the same as they were in 1983.

(d) Section C comprehensive premiums have increased substantially since 1975 although the increase from the previous high point in 1982 is relatively small.

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[20] The composite line includes all and specified perils which are part of Section C coverage.

(e) The composite (all coverages) premium picture, perhaps not surprisingly, follows the same general path as the Section A premium. Even after the substantial 1985/86 increase, composite premiums were still less than premiums in 1977 when measured in constant (1981) dollars.

C. PREMIUMS AND LOSS COSTS

Having separately considered loss costs and premiums I now turn to consider their relationship over the same period 1975-86. At any given time the relationship between loss costs (using undiscounted reserves) and premiums is what insurers refer to as the loss ratio (or in current insurance parlance, the claims ratio). The introduction of operating expenses, as will be dealt with later, converts the loss ratio into what insurers refer to as the combined ratio.

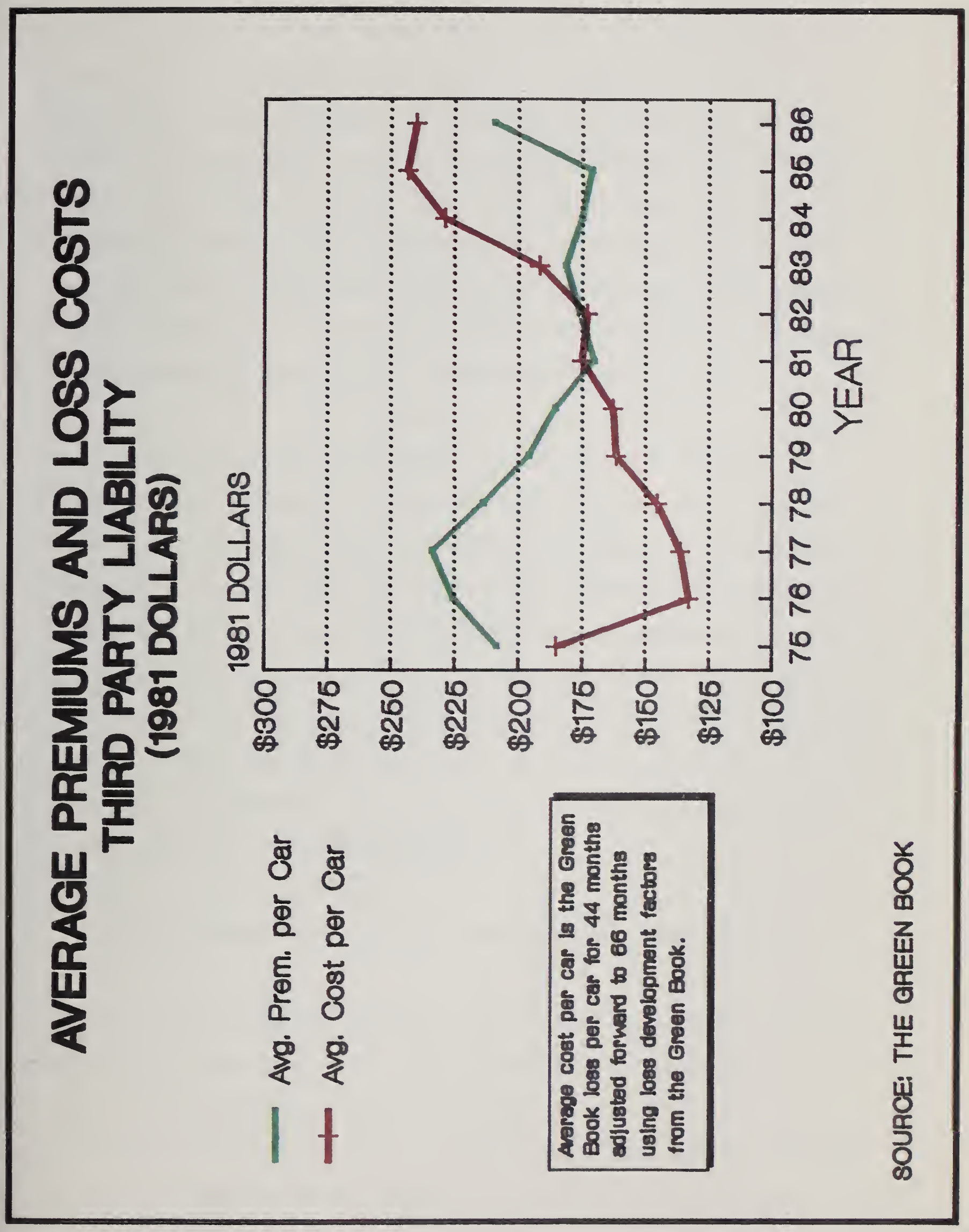
From the outset it seemed to me that there was no useful purpose to be served in examining the loss ratio or combined ratio of any individual insurer. Neither the loss ratio nor the combined ratio takes into account the investment side of the business (unless discounted reserves are used). The relationship between costs and premiums is, in my view, useful only for the purpose of establishing whether there is an appropriate relationship between premiums and actual loss costs. This provides some evidence upon which premiums must be fixed in the future. Both ratios will be affected by increases/decreases in premiums and relevant expenses. Thus, neither can be viewed as a measure of efficiency. Since investment income is excluded from both

calculations, neither the loss ratio nor the combined ratio is a measure of profitability at any given time. In short, both ratios should be looked at with caution.

Figure 7.15 sets out bodily injury/property damage premium and loss cost lines per car insured from 1975 to 1986, adjusted to 1981 dollars. As indicated, when measured in constant (1981) dollars, premiums declined steadily from 1978 to 1981. The 1977 third party cost premium gap would suggest that premiums were reduced starting in 1978, because the industry thought premiums were too high and could safely be lowered. The red "cost" line moved steadily higher from 1982 to its high point in 1985. When the 1982 cost increase started, the green premium line was above the red cost line. In 1984, bodily injury/property damage costs moved quickly beyond bodily injury/property damage premiums. The gap was at its widest in 1985 when premiums were significantly increased (see Figure 7.15). The 1986 premium increase was parallel to the cost increase which started in 1982 and 1983. Bodily injury/property damage costs decreased somewhat in 1986 and continued to decrease very slightly in 1987. As indicated earlier, cost increases in third party liability (Section A) are largely attributable to a small but real increase in average bodily injury claims frequency, and until 1986, the steady increase in average bodily injury claims costs.

The bodily injury/property damage cost/premium gap was at its widest in 1977 when premiums significantly exceeded costs, and in 1985 when loss costs significantly exceeded premiums. Relative stability of premiums from 1981 to 1985 resulted in the one-shot dramatic premium increase in 1986 becoming a consumer/political problem.

Figure 7.15


AVERAGE PREMIUMS AND LOSS COSTS
THIRD PARTY LIABILITY
(1981 DOLLARS)
1981 DOLLARS
$300
$275
$250
$225
$200
$175
$150
$125
$100
75 76 77 78 79 80 81 82 83 84 85 86
YEAR
Avg. Prem. per Car
Avg. Cost per Car
Average cost per car is the Green Book loss per car for 44 months adjusted forward to 66 months using loss development factors from the Green Book.
SOURCE: THE GREEN BOOK

Actuaries and accountants (and in some jurisdictions, taxing authorities) have long recognized that any realistic assessment of an insurer or the insurance industry must consider the insurer's investment income. This is best done by discounting reserves so as to take the time value of money into account. Some insurers have resisted taking this into account, not because it is wrong, but because the insurer's reserving track record has often erred on the low side. Discounting reserves, so the thinking goes, would compound the problem.

More and more insurers are now using standard actuarial techniques to establish reserves for unpaid claims. The time value of money is taken into account, and in my view, must be taken into account, by making a present value calculation to establish appropriate file and I.B.N.R. reserves. If reserves are not discounted, there will be an inevitable mismatch between income and outgo. The Ontario Task Force on Insurance Report refers to the difference between discounted and undiscounted reserves as a "hidden equity".[21]

The present value of a claim reserve depends on:

(a) the amount payable as estimated by the insurer;
(b) the timing of the claim payment, again as estimated by the insurer; and
(c) the interest the insurer can earn while holding the reserved funds.

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[21] Ontario Task Force on Insurance, Final Report (1986), Appendix 8, p. 245.

In practice it is necessary, but difficult, to determine (a) and (b) above on an individual claim basis. When an insurer has several hundred claims, it is possible to establish an aggregate amount required to pay outstanding claims and to establish a general pattern in the timing of claims payments.

For example, at the end of 1988, insurer ABC may estimate that it will require $7-million to pay its incurred claims. Company ABC may be able to establish that on an aggregate, as opposed to a per claim basis, the payment pattern for those claims will be:

a) $3-million in 1989;
b) $2-million in 1990;
c) $1-million in 1991; and
d) $1-million in 1992.

Assuming company ABC can earn 8% net on invested funds, the present value of the $7-million future liability is approximately as follows:

YEAR OF PAYMENT	AMOUNT PAYABLE	PRESENT VALUE AT DECEMBER 31, 1988 AT 8% PER ANNUM
1989	$3,000,000	$2,887.000
1990	2,000.000	$1,782,000
1991	1,000,000	825,000
1992	1,000,000	764,000
	$7,000,000	$6,258,000

As can be seen from the above chart, the impact of discounting reserves is obvious and significant.

The I.B.C. discounted reserves in the actuarial data accompanying its submission to this Inquiry. The I.B.C. and its actuary are to be commended for taking that step.

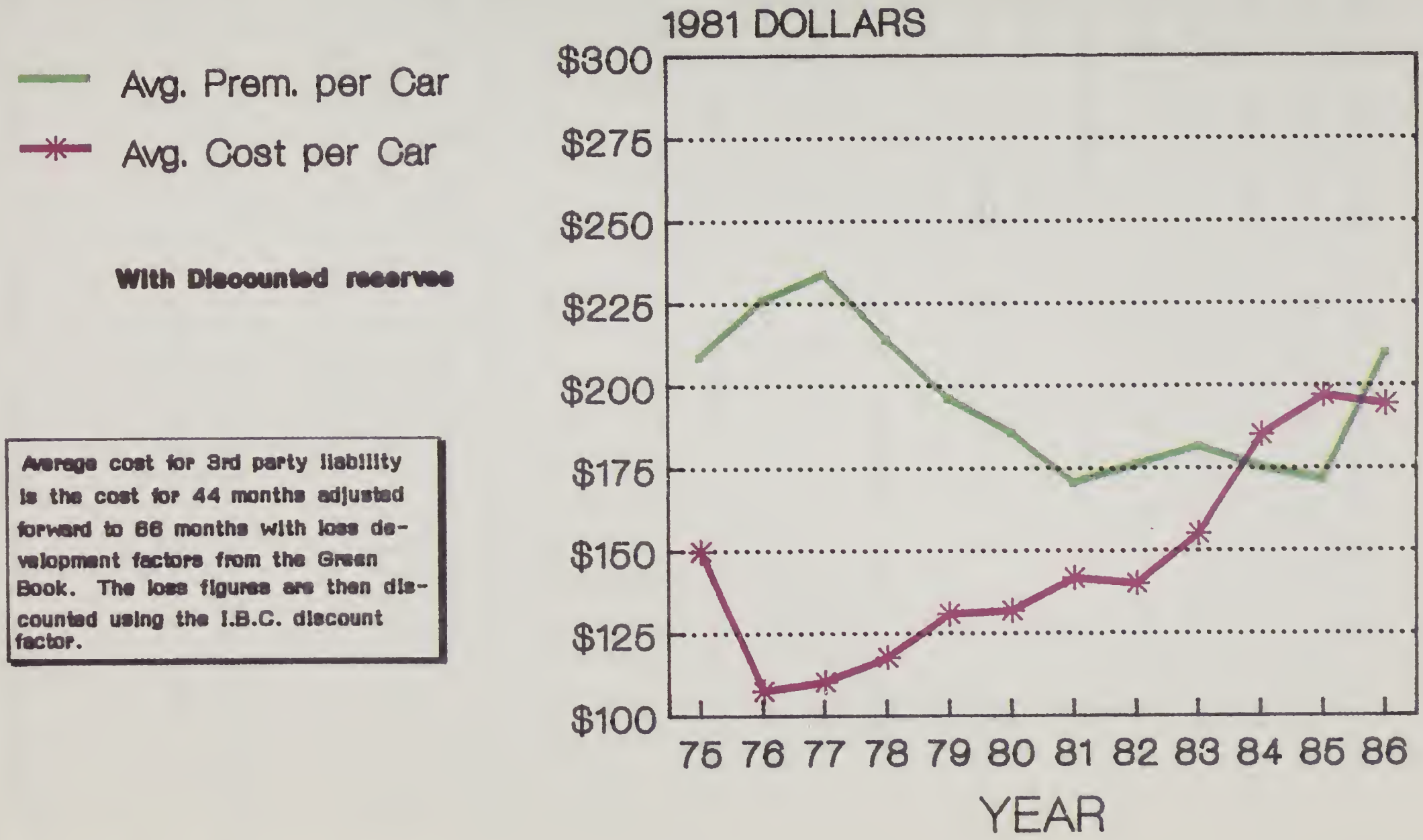
Figure 7.16[22] sets out the same bodily injury/property damage cost/premium picture as Figure 7.15 but with the cost line adjusted to accommodate discounted reserves. As can be seen, discounting reserves lowers the cost line. Assuming reserves are reasonable when considered on an aggregate basis, the cost premium comparison is more realistic when reserves are discounted.

The insurers' explanation that a substantial premium increase in 1986 was required to bring premiums into line with increasing bodily injury loss costs requires some examination. At the outset, even using discounted reserves, I note that it was in fact necessary to increase premiums in 1986. The root cause of the problem occurred much earlier. Premiums were declining from 1977 to their low point in 1981. Loss costs, as indicated, increased moderately in the same period. Loss costs increased steadily and relatively substantially from 1982 through 1985. In this period, third party liability premiums remained stable. There is likely no single explanation for the steady decline in third party premiums between 1977 and 1981. One plausible explanation is that third party premiums were too high in relation to expected loss costs at that time. Another explanation is that high interest rates of the late 1970s and early 1980s Figure

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[22] The third party liability (bodily injury/property damage) discount figure used was the same factor as used by the I.B.C.'s actuary in the I.B.C. submission to this Inquiry.

AVERAGE PREMIUMS AND LOSS COSTS
THIRD PARTY LIABILITY
DISCOUNTED RESERVES (1981 DOLLARS)



With Discounted reserves

Average cost for 3rd party liability is the cost for 44 months adjusted forward to 66 months with loss development factors from the Green Book. The loss figures are then discounted using the I.B.C. discount factor.

SOURCE: THE GREEN BOOK

Figure 7.16

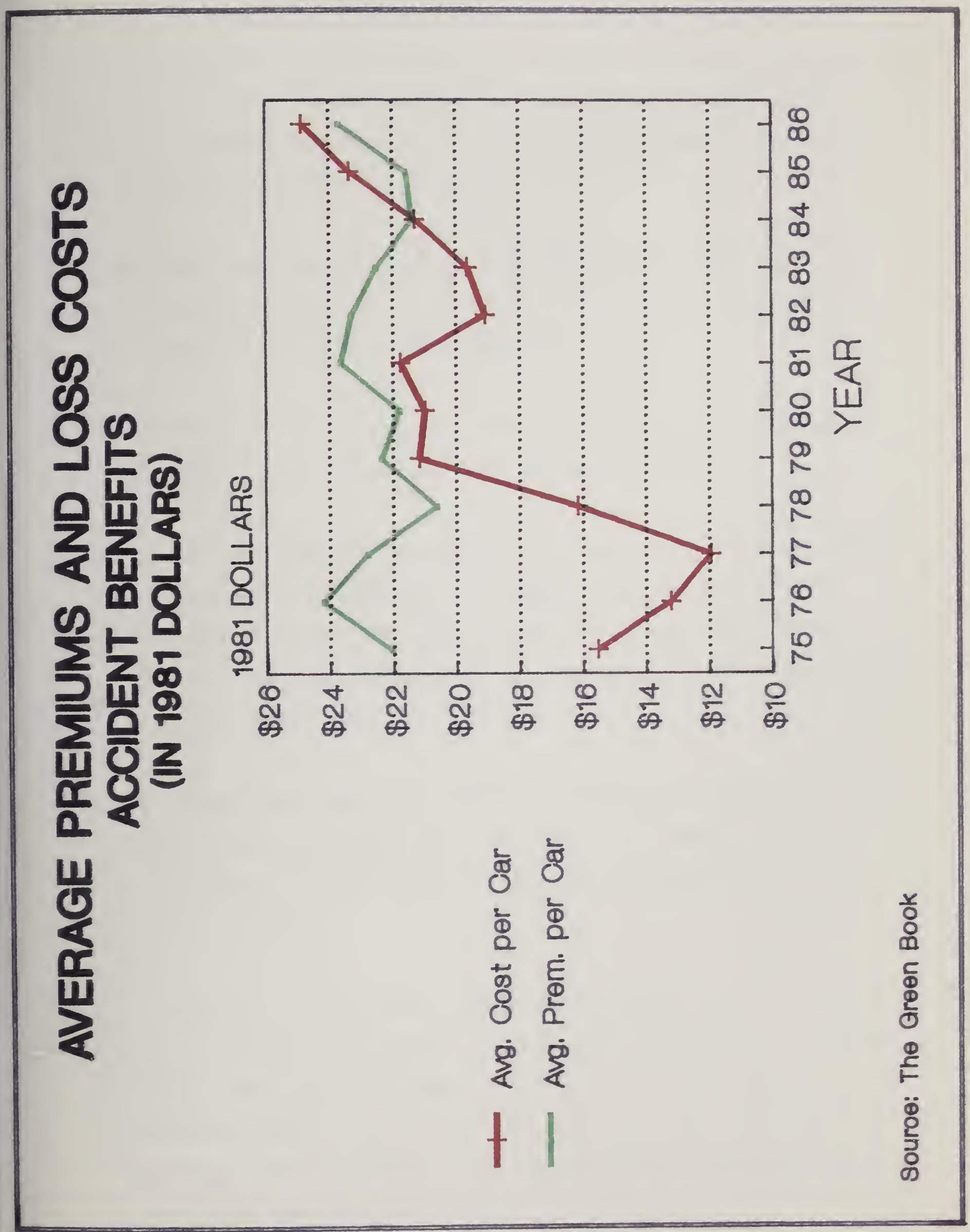
encouraged insurers to be less vigilant in their concerns about expected loss costs than might otherwise be the case. This is the cash flow underwriting syndrome.

By 1982-83 two compounding problems became visible, at least with the benefit of hindsight. First, interest rates began to decline; second, bodily injury claims costs increased, at least in part due to the somewhat late blooming effect of the 1977-78 legislation which introduced prejudgment interest and expanded access to non-pecuniary compensation through the F.L.R.A. Generally, the insurance industry took no real account at any time, and particularly in the early 1980s, of the probable impact of prejudgment interest and F.L.R.A. claims. Even now, insurers do not for the most part capture data as to what is being paid to bodily injury claimants for prejudgment interest or under the F.L.A. Insurers did not take reasonable account of the probability that claims costs would necessarily increase once the recession of the early 1980s ended and relative prosperity returned. The industry collectively responded with a substantial premium increase in 1985-86. If the increase had been introduced gradually, there would have been fewer and less intense complaints.

Figure 7.17 presents the accident benefits (Section B) picture from 1975 through 1986. These conclusions are evident:

(a) Accident benefits premiums per car were significantly higher than accident benefit costs per car until 1978-1979. The greatest cost/premium gap existed in 1976 and 1977.

Figure 7.17


AVERAGE PREMIUMS AND LOSS COSTS
ACCIDENT BENEFITS
(IN 1981 DOLLARS)
1981 DOLLARS
$26
$24
$22
$20
$18
$16
$14
$12
$10
75 76 77 78 79 80 81 82 83 84 85 86
YEAR
Avg. Cost per Car
Avg. Prem. per Car
Source: The Green Book

(b) The 1978 cost increase was attributable to the increase in accident benefits (particularly the increase in the disability benefit from $70 to $140) in 1978. Premiums were not adjusted at that time, probably because pre-1978 premiums greatly exceeded accident benefit costs.

(c) Accident benefit costs remained level from 1979 through 1981, and the decline in 1982 was probably attributable to the recession.

(d) Accident benefit costs have steadily increased since 1982. That increase is a source of concern.

(e) Accident benefit premiums declined from 1976 to 1978. Premiums increased in a ragged fashion from 1978 through 1981, and then slowly declined until 1984, when the declining premium line and the inclining cost line intersected.

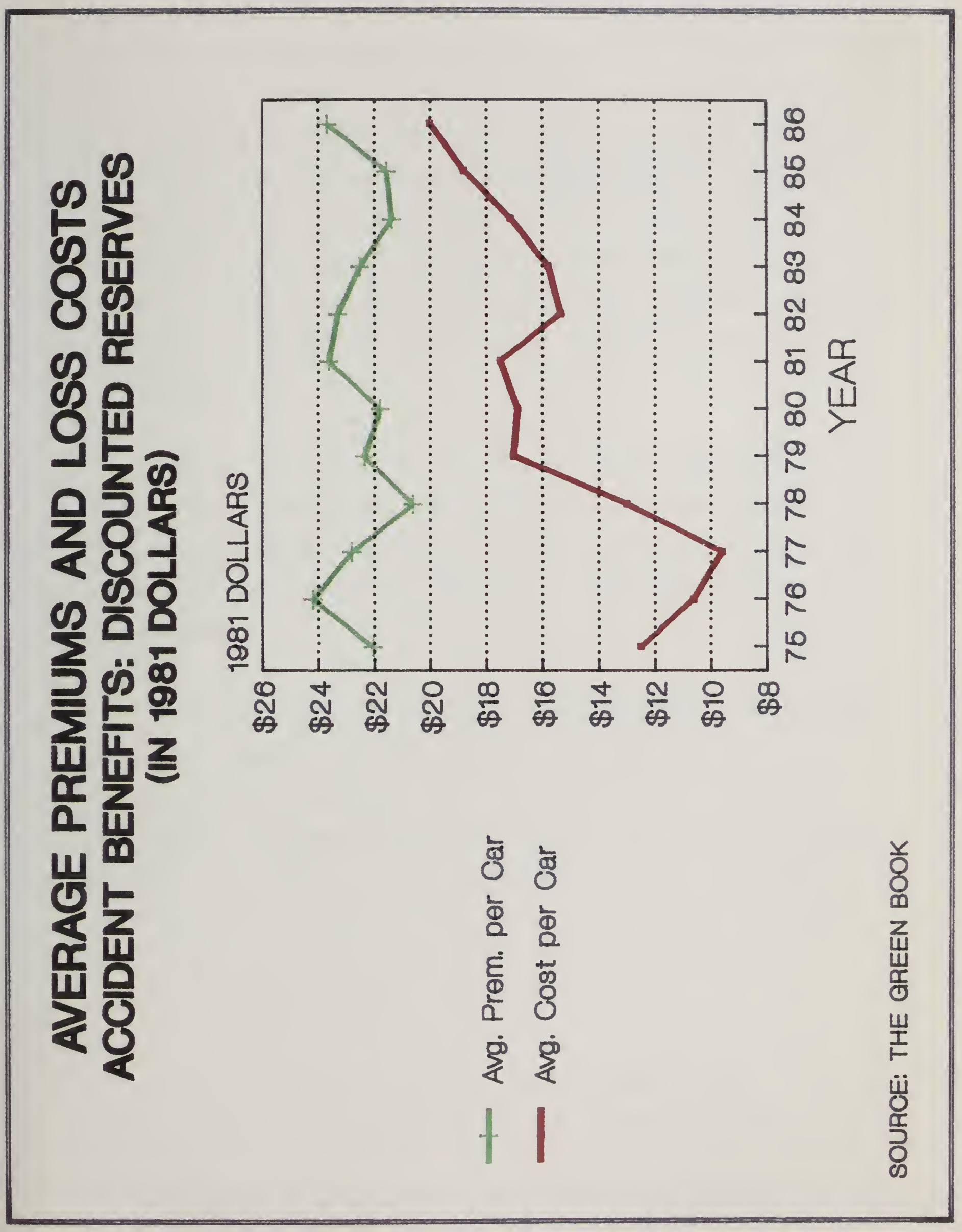
(f) From 1984, accident benefit premiums tracked costs, but premiums from 1984 to 1986 fell slightly below accident benefit costs when reserves are not discounted.

Figure 7.18 mirrors Figure 7.17 except that the cost line has been adjusted to accommodate discounted accident benefit reserves.[23] When reserves are discounted, accident benefit loss costs per car are lowered; the result is that premiums have consistently remained above

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[23] The discount factor used for accident benefits was the same factor used by the I.B.C.'s actuary in the I.B.C. submission to this Inquiry.

Figure 7.18


AVERAGE PREMIUMS AND LOSS COSTS
ACCIDENT BENEFITS: DISCOUNTED RESERVES
(IN 1981 DOLLARS)
1981 DOLLARS
$26
$24
$22
$20
$18
$16
$14
$12
$10
$8
75 76 77 78 79 80 81 82 83 84 85 86
YEAR
Avg. Prem. per Car
Avg. Cost per Car
SOURCE: THE GREEN BOOK

costs. This does not occur when undiscounted reserves are used (Figure 7.17). In the end result, accident benefit premiums seem to be adequate.

Figures 7.19 and 7.20 show average premium and loss costs per car for collision and comprehensive coverage respectively. Collision seems to be a relatively profitable and stable coverage. At no time since 1973 have collision costs exceeded collision premiums. Because collision losses are paid quickly, reserves have not been discounted.

Figure 7.20 shows a relatively stable comprehensive cost line. Comprehensive coverage is not the source of the cost/premium problem although comprehensive costs and premiums have steadily increased. This coverage is profitable.

Finally, Figure 7.21 shows the composite premium cost picture, taking into account all coverage (with undiscounted reserves). It was only in 1985 that the aggregate costs on an industry basis rose above premiums. Figure 7.22 shows the same composite picture but with discounted reserves. Different discounting factors have been used for bodily injury accident benefits and collision/comprehensive coverages.[24]

With discounted reserves, the average bodily injury/property damage cost per car increased from

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[24] Once again, the discount rates used are the same discount rates chosen by the I.B.C.'s actuary who discounted reserves for the purpose of costing the I.B.C.'s threshold no fault proposal.

Figure 7.19

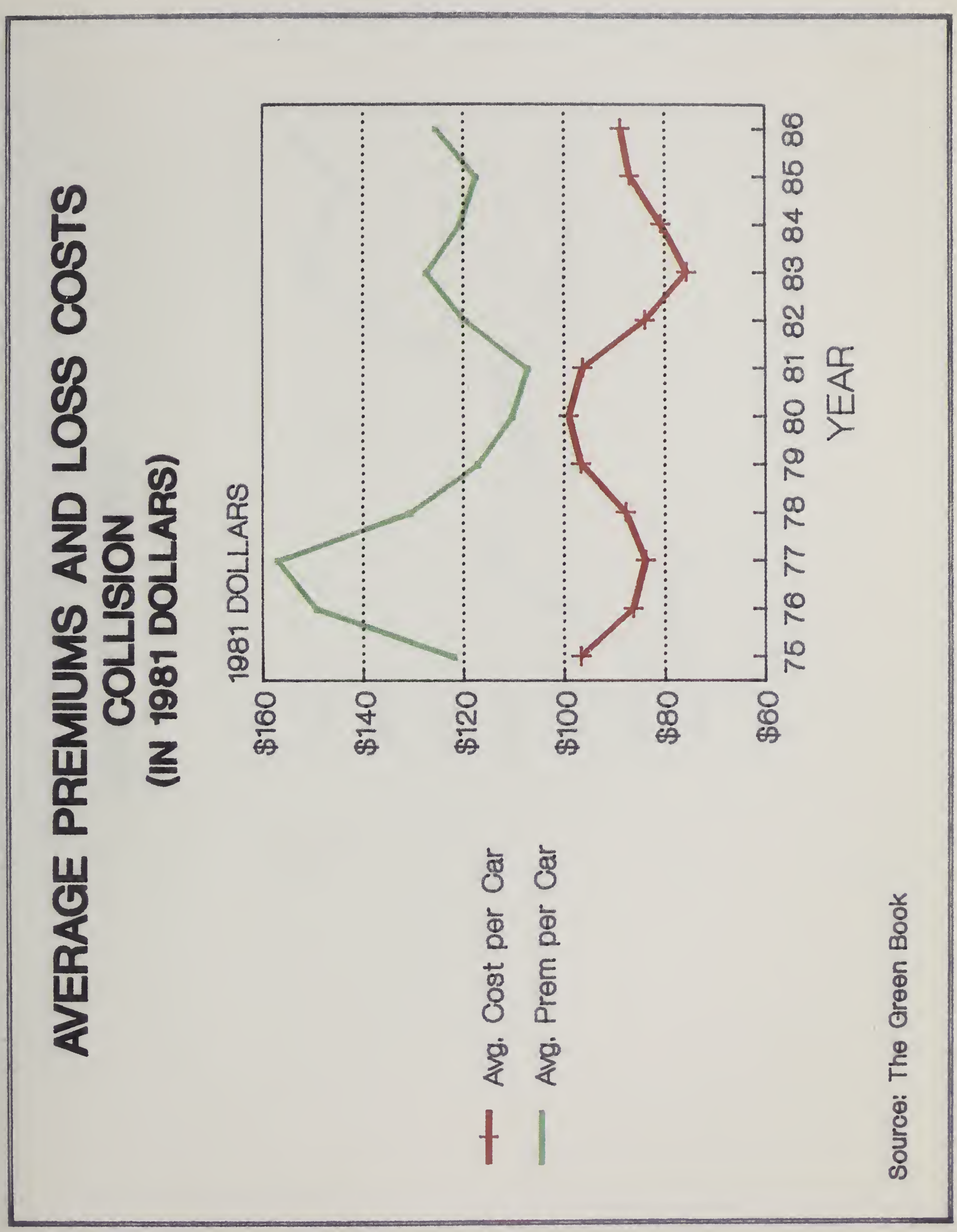

AVERAGE PREMIUMS AND LOSS COSTS
COLLISION
(IN 1981 DOLLARS)
1981 DOLLARS
$160
$140
$120
$100
$80
$60
75 76 77 78 79 80 81 82 83 84 85 86
YEAR
Avg. Cost per Car
Avg. Prem per Car
Source: The Green Book

Figure 7.20

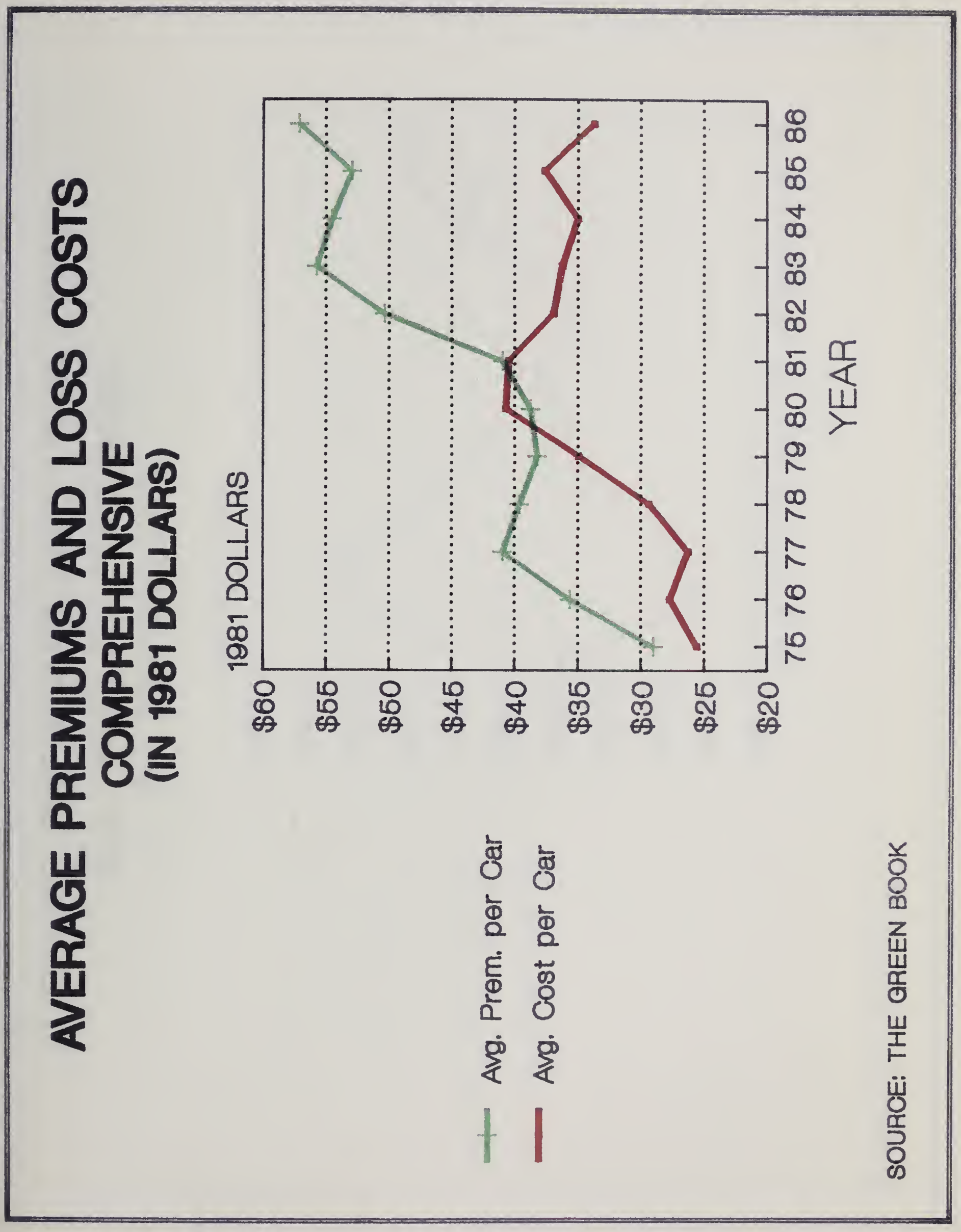

AVERAGE PREMIUMS AND LOSS COSTS
COMPREHENSIVE
(IN 1981 DOLLARS)
1981 DOLLARS
$60
$55
$50
$45
$40
$35
$30
$25
$20
75 76 77 78 79 80 81 82 83 84 85 86
YEAR
Avg. Prem. per Car
Avg. Cost per Car
SOURCE: THE GREEN BOOK

Figure 7.21

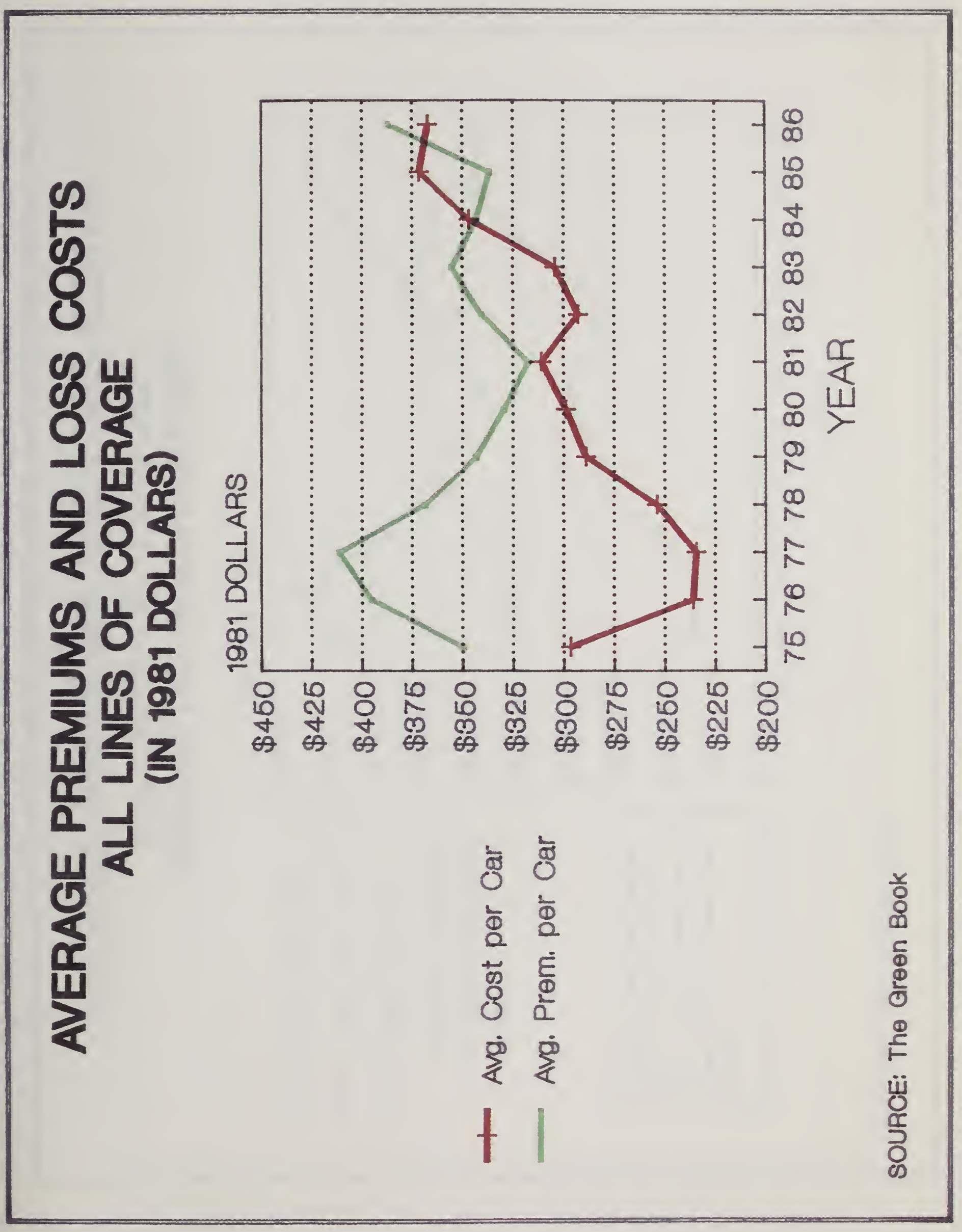
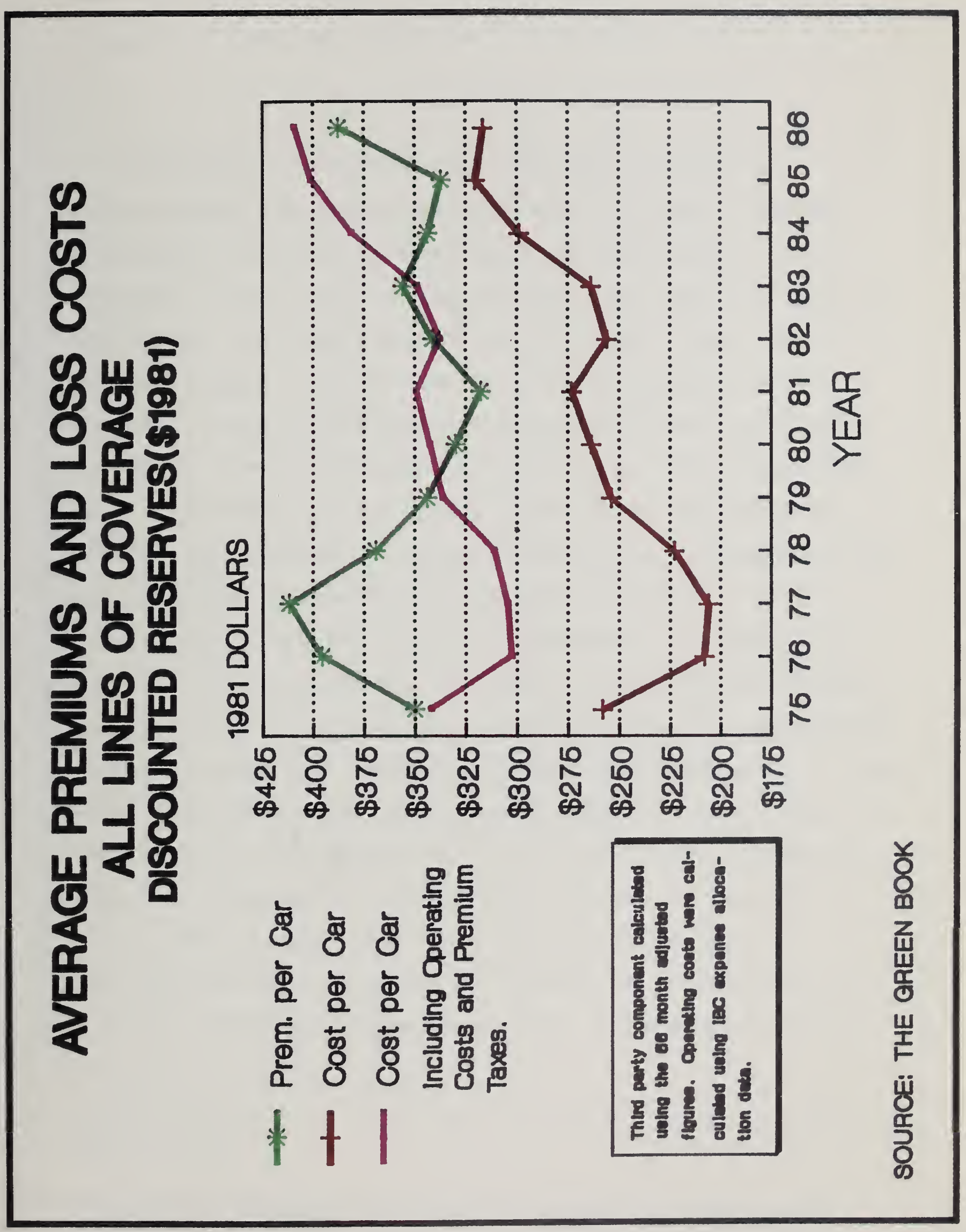

AVERAGE PREMIUMS AND LOSS COSTS
ALL LINES OF COVERAGE
(IN 1981 DOLLARS)
1981 DOLLARS
$450
$425
$400
$375
$350
$325
$300
$275
$250
$225
$200
75 76 77 78 79 80 81 82 83 84 85 86
YEAR
Avg. Cost per Car
Avg. Prem. per Car
SOURCE: The Green Book

Figure 7.22


AVERAGE PREMIUMS AND LOSS COSTS
ALL LINES OF COVERAGE
DISCOUNTED RESERVES($1981)
1981 DOLLARS
$425
$400
$375
$350
$325
$300
$275
$250
$225
$200
$175
75 76 77 78 79 80 81 82 83 84 85 86
YEAR
Prem. per Car
Cost per Car
Cost per Car
Including Operating Costs and Premium Taxes.
Third party component calculated using the 66 month adjusted figures. Operating costs were calculated using IBC expense allocation data.
SOURCE: THE GREEN BOOK

approximately $250 in 1975 to $300 in 1986.[25] With undiscounted reserves the average bodily injury/property damage cost per car increased from $280 in 1975 to $350 in 1986.

Although it is useful to consider the historic relationship between loss costs and premiums, from the standpoint of separate coverage, and as related to all coverage lines (as per Figures 7.21 and 7.22), it must be emphasized that the previously referred to cost and premium figures do not take operating expenses into account. Insurers' operating expenses cannot be ignored in any real world assessment of where we have been, where we are and where we are going from a loss cost/premium standpoint. Claims adjustment expense is included in loss cost figures, but operating expense is not.[26]

Accordingly, a third line (pink) appears on Figure 7.22. The third line manifests the impact of operating expense on the average cost per car. By introducing an operating expense factor, the lower red cost line on Figure 7.22 is moved upward; the new cost line becomes the heavy pink line shown in the middle part of Figure 7.22. Although operating expenses will vary from company to company, I.B.C. data suggest that over the past five years, operating expense for Ontario insurers is approximately 24.3% of earned premiums; therefore, I have arbitrarily

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[25] Both Figures 7.21 and 7.22, as stated, express costs in 1981 dollars.

[26] Operating expenses includes all expenses other than claims adjustment expenses. Premium tax of 3.0% and licence fees of 0.4% have been included as part of operating expense.

used that figure in adjusting the cost per vehicle line (as on Figure 7.22).

Once operating expenses are included, the lines representing the total coverage claims cost per car and the average premium per car bear a significantly different relationship to each other. When operating expense is taken into account, it is evident that insurers were in a precarious position in 1985 before premiums were increased. There is no purpose to be served in attempting to analyze with precision the reason for the 1985 imbalance between loss costs and all operating expense and premiums. It seems reasonably clear that the insurance industry has no one to blame but itself for this situation. The 1985-1986 premium increase brought average premiums to a point slightly below, but reasonably close to, the equivalent cost line as adjusted for operating expenses. (See Figure 7.22). It should be noted that these data are not up to date in that 1986 data reflect loss expense premium experience only to June 30, 1986. Many insurers have indicated that the situation has improved since then.

In conclusion, I make the following observations:

1. The property damage part of third party liability presents no real cost problem and should not be the source of a premium concern.

2. Accident benefits coverage is an area where there has been an increase in average claims cost; however, I do not view the accident benefits part of the policy as being a coverage area where there is a cost/premium problem.

3. There is no cost problem with the optional collision and comprehensive coverage lines. Collision premiums may be higher than justified.

4. Bodily injury frequency has increased. The increase is not insignificant (.88 in 1982 to 1.09 in 1986, i.e., 24%) There is, however, evidence that bodily injury frequency has stabilized. There is some reason to conclude that the long-term frequency trend is down. Moreover, between 1982 and 1986 Ontario moved from recession to relative economic prosperity. An increase in accident frequency was one result. I think it is reasonable to forecast that accident frequency in the short future term should be stable at worst.

5. As long as bodily injury average loss costs per car continue to increase, premiums will increase. It is clear that there is a problem and that it will not simply go away. Costs have to be curtailed or premiums will continue to rise. I note, however, that the 1985-86 bodily injury/property damage premium increases brought

premiums and loss costs into a semblance of balance. There are current indications of moderation within the system at the third party level.[27]

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[27] Two examples are the Court of Appeal's recent F.L.R.A. pronouncements and the Court of Appeal's treatment of future care costs and gross-up in McErlean v. City of Brampton. See the discussion of these matters in Chapters 8 and 10.

CHAPTER 8

THE TORT SYSTEM OF COMPENSATION

A. OVERVIEW

In Ontario, motor vehicle accident victims receive more compensation from tort law than from any other source.[1] Liability in tort rests on the notion of "fault". In order to be compensated by tort law, one must prove that injury or loss was caused wholly or partly by the fault of another.

Under our system of justice, fault or responsibility for motor vehicle accidents is determined by settlement or the civil courts. All motorists are required to operate their automobiles with reasonable care. If a motorist's conduct falls below the standard of reasonable care that the law requires--if, in other words, the motorist is negligent-- a court will order the motorist to compensate victims for their losses or damages.[2]

Tort law seeks to reimburse the accident victims for all of the damages they have suffered. The basic principle for the measure of damages in tort is that the injured person should receive that sum of money which will as nearly as possible restore the victim to the position he or she was in before the accident. Tort law seeks to

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[1] See Samuel A. Rea, Jr., Inquiry Research Study IV.

[2] See generally J.G. Fleming, The Law of Torts (6th ed.-- Sydney: Law Book Co., 1983), Chaps. 1 and 6.

make the victim "whole".[3] Accordingly, innocent victims of motor vehicle accidents receive damages from a court not only for their pecuniary losses but also for their non-pecuniary losses. Pecuniary losses include loss of earnings, medical and rehabilitation expenses and out-of-pocket costs. Non-pecuniary losses are largely related to what is known as pain and suffering or loss of enjoyment of life attributable to the injury.

Liability premised on fault and full redress from the person whose liability is established are the two broad principles on which tort law deals with motor vehicle accident compensation.[4] There has been considerable debate about the role of tort law in dealing with redress for injuries occasioned by motor vehicle accidents. Books and articles attacking the tort system are legion. Many have called for the elimination of tort law compensation altogether for motor vehicle accidents.[5] Others have

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[3] Fleming, The Law of Torts, Chap. 9, pp. 202-24. See Andrews v. Grand & Toy Alberta Ltd., [1978] 2 S.C.R. 229 at 240-242. Dickson, J., for the Court, reiterated the common law principle that in calculating damages for personal injuries, the court must consider what is the pecuniary sum which will make good to the victim as far as money can do, the loss which he has suffered as the natural result of the wrong done to him. Obviously, a seriously injured person can never be put in the position he would have been in if the tort had not been committed. Money cannot substitute for personal health and happiness. In this sense, Dickson, J. recognized that there cannot be "complete" or "perfect" compensation.

[4] P.H. Winfield and J.A. Jolowicz, Winfield and Jolowicz on Tort (12th ed. -- London: Sweet & Maxwell, 1984), pp. 15-16.

[5] See for example, R.E. Keeton and J. O'Connell, Basic Protection for the Accident Victim (1965); J. O'Connell, The Lawsuit Lottery (1979); T.G. Ison, The Forensic

defended the tort system.[6] In this chapter I will sketch the evolution of the fault concept and consider the extent to which it has been modified in 20th century society. I will focus on the evolution of the tort system in relation to motor vehicle accident compensation and on the debate over the continued validity of tort in this area.

I think it is important to recognize that tort law is not the only means by which victims of motor vehicle accidents in this province receive compensation for their injuries. Commencing in 1969 on an optional basis, and since 1972 as required coverage, the standard automobile insurance policy in Ontario has provided for limited accident benefits payable without regard to fault.[7] These

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Lottery (1967); E. Bernzweig, By Accident, Not Design (1980); P.S. Atiyah, "No fault Compensation: A Question That Will Not Go Away," Tulane L. Rev. 54, no. 2 (1980): 271; B. Dunlop, "No fault Automobile Insurance and the Negligence Action: An Expensive Anomaly," Osgoode H. L. J. 13, no. 2 (1975): 439; S.D. Sugarman, "Doing Away With Tort Law," Calif. L. Rev. 73, no. 3 (1985): 558.

[6]See for example, Gary Schwartz, "The Advantages of Tort," Proceedings of a Seminar on Personal Compensation for Injury, Australian National University (1984); W.J. Blum and H. Kalven, "Public Law Perspectives on a Private Law Problem -- Auto Compensation Plans," U. of Chi. L. Rev. 31, no. 4 (1964): 641; A.M. Linden, Canadian Tort Law (3rd ed., 1982), Chap. 1, pp. 1-28; A.M. Linden, "Canadian Tort Law: Yesterday, Today and Tomorrow," Proceedings of the 23rd Conference on Law and Contemporary Affairs at the University of Toronto (1987); L.N. Klar, Speech to Advocates' Society Fall Convention (1986).

[7]See the Insurance Amendment Act, 1966, S.O. 1966, c. 71, s. 11, proclaimed in force January 1, 1969. The Insurance Amendment Act, 1972, S.O. 1972, c. 66, s. 18(1).

no fault benefits are relatively modest.[8] They are intended to supplement rather than supplant compensation through the tort system. The right to sue in tort remains intact for motor vehicle accident victims injured in Ontario (although any no fault payments paid or available under the automobile insurance policy are deducted from the tort award).

In addition to the automobile no fault benefits, there are a host of social welfare plans and private insurance programs available to assist individuals injured in motor vehicle accidents. Unemployment insurance, workers' compensation, general welfare assistance, and short-term and long-term employment disability plans all provide benefits without regard to fault. Virtually every Ontario citizen is covered by hospital and medical care insurance.[9] What this signifies is that the present system of compensation for motor vehicle accident victims is not one based on tort recovery alone. The present Ontario accident compensation system is a mixture of tort and no fault plans, government and private schemes, general social assistance programs and those designed for special groups in society. Admittedly, these various schemes are uncoordinated, have no apparent consistent philosophy and provide an uneven range of benefits. No

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[8] The maximum weekly income indemnity was initially fixed at $70. It was increased to $140 per week in 1978 and has not been changed since then.

[9] See generally, Linden, Canadian Tort Law, pp. 4-5; Samuel A. Rea, Compensation for Automobile Accident Victims in Ontario: A Simulation (1987). -- (Inquiry Research Study IV).

one seriously disputes that better coordination is required.[10]

B. THE EVOLUTION OF FAULT

The word "tort" is derived from the Latin word "tortus" which means twisted or crooked.[11] The expression found its way into the early English language as a synonym for the word "wrong". While "tort" is no longer used in everyday language, it has survived as a technical legal term.

Legal scholars have had considerable difficulty in finding a satisfactory definition of tort. Professor Fleming's is as good as any: "A tort is a civil wrong other than a breach of contract, which the law will redress by an award of damages."[12]

The principal, but not the only focus of tort law today, is on the casualties of accidents, the victims of unintentional yet harmful conduct of others. Liability based on fault or negligence is a development of comparatively recent origin. The earlier common law rule was that each person was strictly liable for the injuries that his conduct caused. Strict liability was premised on

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[10] Some reformers argue for the replacement of the many different compensation plans by a comprehensive disability program. See, e.g., T.G. Ison, "Tort Liability and Social Insurance," U. of T. L. J. 19, no. 4 (1969): 614.

[11] See Lawson v. Wellesley Hospital (1975), 9 O.R. (2d) 677 at 681 (per Dubin, J.A.); affirmed on another point, [1978] 1 S.C.R. 893.

[12] Fleming, The Law of Torts, p. 1.

society's interest in security. The common law was preoccupied with preserving the peace and providing a substitute for private vengeance.[13] The individual interest in security required that the victim be compensated by the person who inflicted the injury regardless of the latter's motivation. Causation, not culpability, was paramount.

Gradually, tort law began to recognize the moral quality of conduct. Moral culpability became the basis for tort law and courts came to accept the principle of "no liability without fault". The notion of fault was firmly planted in a philosophy of individualism, a belief in individual responsibility.[14] This required that those who were at fault for injuring their fellow citizens should face the consequences. It also required that individuals be treated as responsible for deciding what risks to bear and to what extent they should protect themselves from those risks.

The movement from an emphasis on security to an emphasis on freedom of responsible action generally coincided with and was no doubt influenced by the Industrial Revolution in England and the United States in the 19th century. Liability without fault was thought to impede industrial progress because it provided no opportunity to escape liability by being careful. A person would have the unenviable choice of paying the loss

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[13] See Fleming, The Law of Torts, pp. 6-9; R.A. Epstein, "Automobile No-Fault Plans: A Second Look at First Principles," Creighton L. Rev. 13 (1980): 769.

[14] Fleming, pp. 6-9; Atiyah, "No Fault Compensation."

out of his or her own pocket or giving up the activity. Accordingly, fault alone was seen as justifying the shifting of losses from the injured to the wrongdoer. Tort liability was viewed as a deterrent, a method of accident prevention. A judgment against a tortfeasor served as a punishment to the wrongdoer and a warning to others. Tort law was intended to induce citizens to abide by standards of reasonable conduct. The system operated on the underlying assumption that a monetary judgment would be paid out of the wrongdoer's pocket.[15]

The basic principle of "no liability without fault" had significant moral and emotional appeal.[16] It accorded with people's sense of fairness and justice. It was a principle epitomized by the belief that careless people ought to pay for their mistakes. It was entirely reasonable that a given loss be lifted from the shoulders of an innocent victim and placed in the hands of a morally culpable defendant. In this way, the victim was compensated for the loss; the defendant was also punished and the public deterred from similar conduct. Tort law played both a compensatory and a deterrent role.

C. DEVELOPMENTS OF THE TWENTIETH CENTURY

As tort law was concerned with the adjustment of risks and the extent to which injuries to persons and property

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[15] See Fleming, The Law of Torts, Chap. 1.

[16] See for example, P.H. Osborne, A Critical Evaluation of Liability Insurance, Litigation and Personal Injury Compensation: The Lessons and Choices for Ontario. A paper prepared for the Ontario Task Force on Insurance (1986), p. 3.

should be compensated, it was inevitable that it be influenced by changing social conditions. For example, in the early stages of the common law, tort law was mainly concerned with the infringement of protected interests in land. There were few cities and little industry. Industrialization, urbanization, the development of highways and the increasing use of the automobile and other forms of transportation had the effect of broadening the reach of tort law and shifting its emphasis from injury to land to other forms of property interest, and to compensation for personal injuries.[17]

As we advanced into the 20th century, the notion of individual responsibility for social conduct was increasingly challenged by a growing emphasis on the responsibility of the community for losses resulting from accidents. Given a society in which the number of accidents of all kinds was increasing dramatically and was considered by many to be inevitable in the modern world, the traditional principles of tort liability seemed too narrow a basis to address the real compensation needs of accident victims. The result was a dramatic reform in the application and scope of tort law and the proliferation of alternative or additional compensation systems. This led many to conclude that the principal function of tort law had shifted from deterrence of the wrongdoer to compensation of the injured. Where tort law was not seen to be sufficiently responsive to the needs of

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[17] See generally, Wolfgang Friedmann, "Tort, Insurance and Social Responsibility," Chap. 5 in Law in a Changing Society.

the 20th century accident victim, there was pressure to modify its principles or reject them entirely.[18]

Changes in the application of tort law were manifest in a number of ways:

(a) The most radical change was the abandonment of tort law and the notion of fault in the field of work-related accidents. The prospects for an injured worker to recover in tort were severely limited by three common law defences: the fellow servant rule, the contributory negligence defence and the voluntary assumption of risk principle.[19] As industrialization grew, it was considered neither fair nor economical that the accident victim in the workplace be left to fend for him or herself unless these obstacles to recovery could be overcome. Industrial accidents came to be viewed as largely inevitable. The losses from injuries to workers came to be regarded as a "cost" of the enterprise. It was recognized that the employer could bear these costs more easily than workers because employers could pass them on

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[18] For a general discussion of the evolution of tort law see G.L. Priest, "Invention of Enterprise Liability: A Critical History of the Intellectual Foundations of Modern Tort Law," J. Leg. Stud. 14 (1985): 461; I. Englard, "The System Builders: A Critical Appraisal of Modern American Tort Theory," J. of Leg. Stud. 9 (1980): 27.

[19] See generally E. Bernzweig and also W. Friedmann, at pp. 169-171; see also Plant v. Grand Trunk Railway (1867), 27 U.C.Q.B. 878.

to consumers in the form of increased prices.[20] It was out of these sentiments that workers' compensation legislation was born. Ontario's Workmen's Compensation Act of 1914 served as the model for Canada.[21] The common law remedy in tort was abolished. Compensation to injured workers was paid without regard to fault. Payments were financed by employer contributions, thereby internalizing the costs of work-related injuries.[22]

(b) Civil liability shifted in certain situations from the immediate tortfeasor to a third party who for any one of a number of reasons was considered to be in a better position to absorb the burden of compensation. An example of this is the acceptance of the principle of vicarious liability of the master for the torts of his servant.[23] A second example is the liability of the owner of an automobile for the negligence of the driver.[24] Vicarious liability improved the

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[20]G.T. Schwartz, "The Vitality of Negligence and the Ethics of Strict Liability," Georgia L. Rev. 15 (1981): 963; Priest, "Invention of Enterprise Liability," pp. 465-66.

[21]S.O. 1914, c. 25.

[22]In most workers' compensation legislation in the United States, workers retain the right to sue at least third parties (i.e., a party other than the employer).

[23]Friedmann, pp. 168-169.

[24]In Ontario, legislation making the owner of a motor vehicle vicariously liable for the negligence of the driver was first enacted in 1930 with The Highway Traffic Amendment Act, 1930 (No. 2), 20 Geo. V, c. 48, s. 10.

ability of the victim to be compensated, but undermined the notion of fault or moral blameworthiness.[25]

(c) The same might also be said of the legislation that repealed the common law rule of contributory negligence as a complete defence to the plaintiff's recovery.[26] Ontario enacted such legislation in 1924.[27] In the view of some critics, to allow compensation to a person partly at fault was a departure from the traditional fault notion of punishing or deterring a wrongdoer and reflected an increasing concern with the desirability of compensation. On the other hand, it might be said that limiting a defendant's obligation in accordance with his degree of culpability was consistent with the principles of fault.

(d) Both by legislation and judicial interpretation, a variety of defences and immunities that plagued tort law in the late 19th and early 20th century

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[25] See Atiyah, "No Fault Compensation," p. 282. The obligation to pay is imposed on a person who is not morally culpable.

[26] See C.A. Wright, "The Adequacy of the Law of Torts," in Canadian Tort Law/ed by Linden (1968); Atiyah, "No Fault Compensation," pp. 284-285. In Professor Atiyah's view, the repeal of the common law contributory negligence rule has undermined the morality of the fault system more than any other single change in the law.

[27] See The Contributory Negligence Act, S.O. 1924, c. 32. The statute is now known as the Negligence Act; see R.S.O. 1980, c. 315, s. 2.

were gradually eliminated.[28] One example concerns the legislation that precluded a gratuitous passenger from recovering from the negligent driver of the vehicle in which he or she was riding.[29] In 1966, the legislation was amended to permit a gratuitous passenger to recover compensation if insured by the driver's negligence, but only if the passenger could establish "gross negligence".[30] In 1977, the gratuitous passenger was placed in the same position as any person suffering injury or loss because of a driver's negligence. This, of course, is subject to the contributory negligence of the passenger and the now narrow doctrine of volenti non fit injuria.[31]

(e) There has been a steady expansion, particularly in American tort law, of the principle of strict

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[28] See G.T. Schwartz, "Vitality of Negligence and the Ethics of Strict Liability," pp. 963-966. For example, the tort immunity of charitable institutions has been eliminated; inter-familiar immunities increasingly have been discarded, rendering spouses liable to each other and parents liable to their children and vice versa; in addition a broad governmental immunity has been replaced by a selected set of immunity rules.

[29] The Highway Traffic Amendment Act, 25 Geo. V, c. 26, s. 11 (adding s. 10).

[30] The Highway Traffic Amendment Act, 1966, S.O. 1966, c. 64, s. 20(2) (amending R.S.O. 1960, c. 172, s. 105(2)).

[31] The Highway Traffic Amendment Act, 1977 (No. 3), S.O. 1977, c. 54, s. 16. It is generally thought that the judgment of Estey, J. in Dube v. Labar, [1986] 1 S.C.R. 649 has restricted the practical application of the volenti doctrine.

liability. Its most prominent application is in the field of products liability law in the United States.[32]

(f) Negligence principles are now being applied in a variety of new areas.[33] For example, tavern owners may now be liable for failing to prevent their patrons from becoming so intoxicated that they become a danger to themselves and others.[34] Manufacturers of hazardous products now have a

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[32]G.T. Schwartz, "Vitality of Negligence and the Ethics of Strict Liability," pp. 970-972. See also Priest, "Invention of Enterprise Liability," p. 507. At common law, the application of strict liability rules was basically limited to strict liability for trespassing cattle, animals known to be dangerous and ultra-hazardous activities, the latter under the rule in Rylands v. Fletcher (1868), 3 L.R. 330 (H.L.). See also Priest, pp. 507 and William L. Prosser, "The Assault Upon the Citadel (Strict Liability to the Consumer)," Yale L. J. 69, no. 7 (1960): 1,099. The first judicial adoption of strict liability in the United States in the field of consumer products came in Henningsen v. Bloomfield Motors Inc., 161 A. (2d) 69 (1960) and Greenman v. Yuba Power Products Inc., 377 P. (2d) 897. In Henningsen, the New Jersey Court ruled that a disclaimer in a product warranty excluding consequential personal injury was void as against public policy. In Greenman, the California Supreme Court led by Chief Justice Traynor announced the standard of strict tort liability for personal injuries caused by products. In 1964, the American Law Institute in its Re-statement (2d) of Torts adopted Section 402A which assigns liability to sellers for injuries from products in a defective condition and unreasonably dangerous though the seller has exercised all possible care in preparing the product.

[33]See Trebilcock, The Insurance-Deterrence Dilemma, pp. 31-33.

[34]Jordan House Ltd. v. Menow and Honsberger (1974), 38 D.L.R. (3d) 105 (S.C.C.).

> stringent duty to warn consumers of the attendant dangers of their products.[35] Accountants may be liable to potential investors in a company for negligently prepared financial statements.[36]

Two other significant 20th century developments have greatly influenced the tort law system. The first was the widespread application of third party or liability insurance; the second was the proliferation of a number of first party insurance programs, both public and private, which were designed to provide income and medical protection to the victims of accidents.

Liability insurance has become commonplace. It has advantages for both the wrongdoer and the victim. It affords the wrongdoer some protection against the possibility of financial ruin. It assures the victim that his right to recover will not be illusory because the defendant happens to lack the financial resources to meet his legal obligations. The Pearson Commission in England reported that 94% of all tort damages in that country come from insurance sources and probably much of the balance is paid by self-insurers.[37] To the extent that the fault principle requires individuals to pay for their own mistakes by shifting to them the burden of the loss caused by their morally blameworthy conduct, the principle has

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[35] Lambert v. Lastoplex Chemicals Co. Ltd. (1972), 25 D.L.R. (3d) 121 (S.C.C.).

[36] Haig v. Bamford (1977), 72 D.L.R. (3d) 68 (S.C.C.).

[37] U.K. Royal Commission on Civil Liability and Compensation for Personal Injury. Report. - London: H.M.S.O., 1978. (Henceforth: Pearson Commission).

been severely compromised by the advent of liability insurance.[38] The risk of loss falls not on the potential wrongdoer but is spread over time among the insurer's policyholders. With the accident prevention aspect of tort law diluted, compensation came to be viewed as the system's predominant function.

Liability insurance also meant that losses from accidents were no longer shifted from one individual to another. Instead, the costs of accidents were transferred from individuals to the industrial enterprise and to the insured activities that generated these accidents. Enterprises in turn spread the costs by increasing prices to consumers. This focus on loss distribution and the internalization of costs of a particular activity led to the enterprise theory of liability which significantly influenced the development of modern American tort law.[39]

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[38] Defendants still remain personally liable for any judgment in excess of their insurance coverage. It has also been suggested that tort law might also deter because of adverse publicity resulting from some tort actions and because at least some people do not relish being found liable by a court judgment. There is also potential for deterrence on the pricing of insurance premiums. To the extent insurance prices respond to changes in the level of care of individuals they may provide an incentive to safe conduct. Some tort scholars, such as Professor Gary Schwartz, are of the view that liability insurance is consistent with the notion of fault in that it enables the defendant to discharge his responsibility to the plaintiff.

[39] The phrase "enterprise liability" suggests that tort law can relieve the burden on individual victims by spreading their losses through price adjustments or liability insurance. See generally, G.L. Priest. The work of the American tort scholar, Fleming James, was very significant to the development of modern American tort law. James viewed personal injury damage judgments as a form of "social insurance". He saw accidents as

First party insurance has also affected the impact of the tort system. In Canada over the last half century, various first party social insurance programs -- unemployment insurance, sickness and disability plans, welfare programs, hospital and medical care plans -- have been implemented to cushion individuals from economic losses. These compensation mechanisms reflected the view that fault was too narrow a concept to solve all of the economic problems of a growing number of accident victims. The development of these social welfare schemes meant that the failure to recover in tort was not as significant as it once was.

D. TORT AND MOTOR VEHICLE ACCIDENT COMPENSATION

Although a no fault system of compensation for workplace accidents is now almost universally recognized, in the field of motor vehicle accidents most jurisdictions allow access to the tort system.[40] One explanation for this difference lies in the fact that the relationship between the motorist and the accident victim is completely different from the relationship between employer and employee. Moreover, historically, workers'

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inevitable consequences of productive activity and conceived the principal function of tort law to be compensation of the injured. He believed that what was required was to shift losses from plaintiffs who could ill afford to bear them to defendants able to spread them broadly over society by insurance or by adding some small increment to the prices of their products.

[40]No fault has not established the same presence in connection with motor vehicle accidents as it has in the workplace.

compensation legislation came about because of the need to protect economically disadvantaged industrial workers from the risk of loss resulting from injury whereas, originally, automobile owners were relatively few in number and were generally well-to-do. By the time automobile use became widespread, many countries in the western world had developed a variety of comprehensive social insurance and social security systems which reduced the pressure to abolish tort liability. Another explanation may lie in the fact that both the legal profession and the insurance industry[41] had a great deal at stake in the maintenance of the existing system and were able to exert a considerable influence against the widespread adoption of no fault systems of compensation.[42]

Nonetheless, for over a half-century there have been cries for comprehensive reform of the system of compensation for motor vehicle accidents. In North

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[41]The insurance industry in recent years, at least in Canada, has altered its position on no fault. In the mid-1970's, the insurance industry in Ontario proposed "Variplan", a form of threshold no fault. While the I.B.C. in its submission to the Ontario Task Force on Insurance argued for the maintenance of the existing tort system, before this Inquiry, the I.B.C. argued for threshold no fault.

[42]See generally, Friedmann, pp. 171-173. It may also be observed that a workers' compensation regime deals with a very specialized population. All claimants for no fault benefits are employed at the time of their injury and are involved in accidents arising out of and in the course of their employment. It is arguably more difficult to construct an efficient plan for motor vehicle accident victims since the plan has to include benefits for the unemployed, students, older people, self-employed and those at home maintaining the house and caring for children.

America, the 1932 Columbia University Committee Plan was the starting point for all subsequent attempts to reform the system.[43] The Columbia Plan proposed two basic changes in the tort system of compensation. First, it proposed legislation that would impose on the owners of motor vehicles a limited liability without regard to fault for personal injuries or deaths. Second, it proposed compulsory automobile insurance. As in the case of workers' compensation legislation, the remedy provided under the schedule of benefits would be an exclusive remedy completely replacing the right to recover at common law.

The Columbia Plan was the forerunner of the plan introduced by the Province of Saskatchewan in 1946.[44] The Saskatchewan Automobile Accident Insurance Act provided a schedule of modest no fault benefits but, unlike the Columbia Plan, permitted an automobile accident victim to obtain further compensation by suing in tort.

Apart from these initiatives, there was little interest outside academic quarters in any form of no fault compensation for automobile accident victims until 1965[45]

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[43] Columbia University. Committee to Study Compensation for Automobile Accidents. Report to the Columbia University Council for Research in the Social Sciences, 1932; and see Friedmann, pp. 173-174.

[44] Friedmann, pp. 174-75.

[45] For a summary of reform proposals put forward in the United States following World War II, see Morris and Paul, "The Financial Impact of Automobile Accidents," U. of Penn. L. Rev. 110, no. 7 (1962): 913. Ison criticizes the phrase "no fault" as a misleading label for reform on the ground that it implies the problems with tort liability are rooted in the fault principle. For Ison the basic

when Professors Keeton and O'Connell published their landmark text, Basic Protection for the Traffic Victim.[46] Keeton and O'Connell strongly condemned the tort system and proposed a model statute which would limit the right to sue in return for guaranteed no fault benefits for income losses and medical expenses.

Keeton and O'Connell did not stand alone. The Report of the Royal Commission of Inquiry into Compensation for Personal Injury in New Zealand contained a powerful attack on the common law method of compensation.[47] Law review articles were highly critical of the way in which the tort system dealt with accidental injury.[48] The arguments of Keeton and O'Connell and others who favoured the elimination of the tort system and its replacement by a no fault system of compensation were made in persuasive terms.[49] At the risk of oversimplification, their main arguments may be summarized as follows:

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problems result from the use of any liability system at all. See Ison, "The Politics of Reform in Personal Injury Compensation," at p. 387.

[46]Keeton and O'Connell, Basic Protection for the Traffic Victim.

[47]New Zealand. Royal Commission to Inquire into and Report Upon Workers' Compensation, Compensation for Personal Injury in New Zealand (1967); G. Palmer, Compensation for Incapacity: A Study of Law and Social Change in New Zealand and Australia (1979).

[48]For a summary, see Priest; Morris and Paul.

[49]See Robert E. Keeton, "The Case For No-Fault Insurance," Miss. L. J. 44 (1973): 1, and Ison, "The Politics of Reform," U. of T. L. J. 27 (1977): 385 which, among many articles, summarizes the case for no fault compensation.

(a) Uncompensated Victims

Because there was a requirement to prove fault, some injured persons received no compensation. Some injured persons received no compensation or less than their economic losses even when fault could be established.[50] Several studies indicated that less than half of those killed or injured in motor vehicle accidents received any compensation from the tort system.[51] One of these studies was the Report of the Osgoode Hall Study on Compensation for Victims of Automobile Accidents, published in 1965.[52] It reported that 57% of motor vehicle accident victims in Ontario failed to recover anything from tort claims. Those in favour of no fault believed that

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[50] It may also be said that some plaintiffs settle for less than full compensation because of delay, immediate financial need and so forth.

[51] The United States Department of Transportation study entitled Motor Vehicle Crash Losses and their Compensation in the United States published in 1971 reported that only 45% of all of those killed or seriously injured in motor vehicle accidents received anything by way of damages from the tort system. A Michigan study showed that 63% of those injured on the roads in that state failed to recover. See A. Conard et al., Automobile Accident Costs and Payments (1964). A survey of 12,000 households in the United Kingdom carried out by the Centre for Socio-Legal Studies at Oxford University found that of the motor vehicle accident victims, only 31% derived some tort damages. In 1978, the Pearson Inquiry in the Report of the Royal Commission on Civil Liability and Compensation for Personal Injury, reported that only 6.5% of all those suffering injuries secure any tort compensation.

[52] See A. Linden, The Report of the Osgoode Hall Study on Compensation for Victims of Automobile Accidents, (1965).

virtually all accident victims would prefer the certainty of indemnification for their loss of earnings and medical expenses to the possibility of recovering an award of damages both for their economic losses and for pain and suffering.[53]

(b) Delay

Even when the tort system did provide compensation, it was viewed as being too slow in making payments. A no fault system, it was argued, could deliver compensation to the victim and his dependants much more quickly. The delay in making payments in the tort system arises not only from the time needed to investigate and determine the question of fault but also from the tort system's emphasis on the once-and-for-all lump sum payment. In this environment, damages cannot be assessed until the extent of the victim's recovery is known.[54] The delays varied among jurisdictions, but in many places they were measured in years, not months. In practical terms, delay meant that tort was not effective as a source of support for the accident victim in the weeks and months immediately following the accident.

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[53] See for example, O'Connell, Lawsuit Lottery (1979), pp. 188-189.

[54] See Palmer, p. 24; Keeton, "The Case For No-Fault," pp. 3-4; Ison, "Politics of Reform," p. 386.

(c) Inefficiency

The tort system was also attacked as being inefficient and expensive. It was argued that too much of the insurance premium dollar was spent on administrative and claims-related expenses necessary to the investigation of fault and too little was returned to the accident victim by way of compensation.[55] By contrast, a no fault regime was said to return more of the premium dollar to the victim by way of compensation.[56]

(d) Lack of Deterrence

It was alleged that tort no longer fulfilled its historic function of accident prevention or deterrence. Liability insurance had undermined the tort system's usefulness as a deterrence mechanism.[57] To the extent that deterrence was

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[55] See for example, Keeton, "The Case for No fault," p. 5 where he reports that the American Insurance Association cost study in 1968 demonstrated that only 44 cents out of every dollar in insurance premiums goes to pay the victim. The report of the British Columbia Royal Commission on Automobile Insurance in 1973 indicated that $1.60 in premiums was needed in order to deliver $1.00 in compensation to the accident victim.

[56] It is particularly argued that the claims administration costs are significantly higher in a tort system than in a no fault system.

[57] See for example, Palmer, p. 24; Dunlop, "No Fault Automobile Insurance and the Negligence Action: An Expensive Anomaly," pp. 445-446. Related to the deterrence argument is that tort, unlike no fault, has a role in educating the public as to the expected standard of behaviour. The counter-argument is that since only a small percentage of motor vehicle accident claims ever reach the courts and only a tiny percentage of those get

important in the motor vehicle context, fear of injury to oneself, higher insurance premiums and the proper use of regulatory and criminal law sanctions were said to be far more effective deterrents to unsafe driving.[58]

(e) Inadequacy of Fault as a Basis for Liability

The fault principle itself was attacked as being an inadequate criterion of liability in personal injury cases. Those in favour of no fault argued that few accidents involved true moral blameworthiness. Most were the result of errors in judgment for which the notion of fault was ill-suited.[59] The extent of the defendant's liability did not necessarily bear any relationship to the quality of his conduct. The most reprehensible driver conduct could result in the most minor of injuries while a moment's inadvertence or human error could lead to a catastrophic loss. Finally, many commentators argued that the fault finding process itself was unrealistic.[60] The personal injury trial was

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any significant publicity which, in any event, is likely to educate more as to the level of damage awards than as to the standard of care, it is an elaborate and expensive system to be maintained for such a dubious return.

[58]See New York (State) Insurance Department, Automobile Insurance...For Whose Benefit? (New York, 1970) at p. 12 and Ontario Task Force on Insurance, Final Report (1986).

[59]Keeton, "The Case for No-Fault," p. 6; Bernzweig, By Accident, Not Design.

[60]Dunlop, "No Fault Automobile Insurance and the Negligence Action: An Expensive Anomaly," pp. 445-446 where the author stated:

likened to a "forensic lottery".[61] In the words of the late Caesar Wright:

> Motor vehicle accidents are events which occur suddenly, taking the witnesses, including the participants, by surprise and resulting in imperfect perception. Months, even years, after the event, they are called upon to assess distances, relative speeds, time elapsed; all matters to which they have little or no experience. It is expecting too much of the trial process, effective as it may be generally, to elicit from them the truth, no matter how sincere the witnesses may be.

See also Green, Traffic Victims: Tort Law and Insurance (1958). For a contrary view, see Blum and Kalven, "Public Law Perspectives on a Private Law Problem -- Auto Compensation Plans," pp. 646-653. The authors argue that all adjudication, not simply the motor vehicle accident lawsuit is vulnerable to the inadequacies of evidence and the consequent exploitation of the situation by the skill of counsel. See also Spangenberg, "No-Fault Fact, Fiction, and Fallacy", Miss. L. J. 44 (1973): 15.

[61] The phrase is originally Professor Ison's. O'Connell in The Lawsuit Lottery states:

> The operation of the tort system is akin to a lottery. Most crucial criteria for payment are largely controlled by chance:
>
> (i) Whether one is "lucky" enough to be injured by someone whose conduct or product can be proved faulty;
>
> (ii) Whether that party's insurance limits or assets are sufficient to promise an award or settlement commensurate with losses and expenses;
>
> (iii) Whether one's own innocent or faulty conduct can be proved;
>
> (iv) Whether one has the good fortune to retain a lawyer who can exploit all the variables before an impressionable jury, including graphically portraying whatever pain one has suffered.

> Lawyers supporting the trial jury are willing to admit that in the ordinary automobile accident the case that is actually tried by a jury is the case that never in fact took place and is the result of conjectural recall, imagination, colourful dramatization, and pure inventiveness.[62]

(f) **Assessment Difficulties**

It was argued that the tort system had a marked tendency to overcompensate minor injuries and to undercompensate those most severely injured. It was further argued that the assessment of lump sum future loss compensation was a speculative exercise. By comparison, a no fault regime could provide reviewable, periodic payment of compensation.

(g) **Rehabilitation**

The tort system was also viewed by its detractors as being particularly subversive of the rehabilitation of accident victims.[63] The tort system, it was alleged, would not provide the early intervention that is critical to the rehabilitation of the injured. Moreover, successful rehabilitation requires the victim to focus on future potential rather than past

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[62] Wright, "The Adequacy of the Law of Torts," in Studies in Canadian Tort Law/ed. by Linden; see also J.C. McRuer, "Liability Without Fault in the Law of Torts" in Changing Legal Objectives/ed. by Macdonald (1963), pp. 63-64. Former Chief Justice McRuer stated "I do not think Dean Wright has overstated the case, but I would not restrict his comments to those cases tried by a jury".

[63] Palmer, p. 25; Dunlop, pp. 443-444; see also T.G. Ison, "The Therapeutic Significance of Compensation Structures," Can. Bar Rev. 64, no. 4 (1986): 605.

> tragedy. Delayed lump sum tort system compensation provides a disincentive to early rehabilitation because the victim fears that appearing before a court fully healed or rehabilitated may reduce compensation.[64]

The concerted criticism of the tort system did have an impact. Many common law jurisdictions introduced legislation in the late 1960s and early 1970s to address motor vehicle accident compensation problems. The legislative response generally took one of three forms. The first and least extreme response was to provide automobile accident victims with limited first party no fault benefits without in any way restricting their right to sue in tort. The tort system was preserved, but with add-on no fault benefits. The second response, more radical in nature, was to provide victims with no fault benefits and abolish the right to tort law compensation for less severe injuries, but to permit a victim to recover damages if the victim could establish that the injuries met a prescribed threshold. The third response, most radical of all, was to make first party no fault compensation exclusive.

Among reforms to the tort system of compensation, add-on no fault benefits have attracted the widest support. The continuation of the tort system with add-on first party benefits was pioneered in Canada by Saskatchewan in 1946,[65] Ontario in 1969,[66] and British

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[64] Palmer, p. 25.

[65] See Linden, Canadian Tort Law. - 3d ed., pp. 629-31.

Columbia in 1970. Now all Canadian provinces except Quebec have legislation which provides first party no fault benefits to motor vehicle accident victims, but which in no way limits the right of the victim to a tort action.[67] A number of American state legislatures adopted this model as did two Australian states, Victoria and Tasmania.[68]

As the term implies, no fault benefits are paid to injured persons whether or not they are at fault. The amount and nature of the no fault benefits varied from jurisdiction to jurisdiction. Generally, they provided for some measure of income replacement, medical and rehabilitation expenses and death benefits. No fault benefits provided to a greater or lesser extent protection to the accident victim for his or her pecuniary losses. They were paid relatively quickly. For those with a tort action, they provided a measure of support until the action could be settled or tried. For those at fault, they provided some indemnification for financial losses.

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[66] See footnote 7, infra.

[67] No fault benefits are compulsory in all provinces other than Newfoundland, which retains an optional plan.

[68] See generally, Fleming, The Law of Torts, pp. 371-372. The state of Victoria proposes to implement a threshold compensation plan effective June 1988.

Threshold no fault plans originated in the United States.[69] They went beyond add-on plans and took the further step of abolishing tort actions for some injuries. The threshold was either set according to a monetary standard (for example, medical expenses of $1,000) or a verbal standard (for example, "serious impairment of body function") or a combination of both. A plaintiff could only recover non-economic compensation if the plaintiff's injuries (or disabilities) met or exceeded the relevant threshold. Costs saved in excluding cases below the threshold were to be used to finance the cost of no fault benefits for all accident victims thereby containing the costs of insurance premiums. At the same time, it was intended that the less serious injuries, which many regarded as being overcompensated by the tort system, would be taken out of the courts while those innocent victims who were more seriously injured maintained the right to sue for non-economic damages, as well as economic loss beyond that paid through no fault benefits.

Massachusetts was the first American state to enact a threshold no fault law. Its statute was passed in 1970, effective January 1, 1971.[70] In the succeeding few years, several other states passed similar modified no

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[69] See generally, Fleming, Law of Torts, pp. 372-373; U.S. Department of Transportation study: Compensating Auto Accident Victims (1985); James K. Hammitt et al., Automobile Accident Compensation, vol. 4: State Rules (Santa Monica, CA: Rand Corporation, 1985).

[70] Mass. Gen. Laws Ann., Chapter 90 effective 1/1/71. Puerto Rico also brought in a threshold scheme effective 1970. Puerto Rico Laws Ann. Title 9, Section 205.

fault laws. By the mid-1970s, eighteen U.S. states had mandatory threshold no fault plans.[71]

The adoption of these threshold plans in the United States must be viewed in their political and social context. In some respects, threshold no fault represented a political compromise between those who favoured the elimination of the tort system and those who favoured its preservation. Threshold no fault was also viewed as a way to control rising insurance premiums. The adoption of threshold no fault was also influenced by the particular difficulties that an accident victim seeking compensation faced in the United States -- difficulties that were not prevalent in Canada. Most states in the 1960s operated under the common law rule of contributory negligence. If an injured person was even slightly at fault in an accident, he or she recovered nothing. Ontario abolished the all-or-nothing common law rule by statute in 1924.[72] Most American jurisdictions did not substitute a rule of "comparative negligence" until the 1970s.[73] Another difficulty concerned liability insurance coverage. While

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[71]U.S. legislation is summarized in the 1985 Department of Transportation study and in the study by Hammitt et al. for the Rand Corporation (1985). See footnote 74, infra.

[72]S.O. 1924, c. 32.

[73]See Hammitt et al., Automobile Accident Compensation, vol 4: State Rules, pp. 4-7. Canadian and American terminology is different. The modern Canadian contributory negligence rule whereby a plaintiff even partly at fault can recover damages in a tort action (reduced in accordance with the plaintiff's degree of fault) is called the comparative negligence rule in the United States. It would appear that over 30 states in the U.S. did not adopt some form of comparative negligence rule until the 1970s.

third party insurance was mandatory, American limits were very low, at least when measured by our standards and their judgments.[74] There were and still are large numbers of uninsured motorists in many American cities. The result was that many accident victims were undercompensated or left with unsatisfied judgments. There were also difficulties with the court system. Crowded court dockets and long delays added to the plight of those injured in motor vehicle accidents. Finally, the comprehensive social insurance and medical and hospital care programs that developed in Canada and other common law jurisdictions were largely absent in the United States.[75] All of these factors in varying degrees made an impact on the decisions of various state legislatures to enact no fault laws.

Only two common law jurisdictions have taken the extreme step of abolishing all tort actions for compensation for motor vehicle accidents. Following a Royal Commission of Inquiry,[76] New Zealand in 1974 instituted a comprehensive system of compensation on a no fault basis not only for workplace and motor vehicle

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[74] No Canadian province with the tort system has minimum third party limits less than $200,000. In most American states, the compulsory third party limits are well under $100,000. For example, in New York State, compulsory coverage is $10,000/$20,000 and in Michigan $20,000/$40,000.

[75] See Friedmann, p. 178.

[76] New Zealand. Royal Commission to Inquire into and Report Upon Workers' Compensation, Compensation for Personal Injury in New Zealand. Report of the Royal Commission of Inquiry (1967), known as the Woodhouse Inquiry.

accidents, but for all "personal injury by accident".[77] The New Zealand plan is publicly administered by the government-operated Accident Compensation Corporation. In 1978, the Parti Quebecois government in Quebec launched a pure no fault plan for the compensation of motor vehicle accident victims administered by a government board.[78] The New Zealand and Quebec systems are discussed in greater detail in Chapter 11.

E. TORT REFORM[79]

In the last decade, legislative enthusiasm for restricting or abolishing access to the tort system for motor vehicle accident compensation has diminished. No new schemes have been implemented and two states in the United States have repealed their threshold plans in favour of add on no fault benefits.[80] The new direction of reform has been to make changes in the tort law system itself. Principles governing liability and the assessment of damages have undergone legislative and judicial modification.

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[77] Accident Compensation Act, 1972, Statutes of New Zealand 1975, Volume II, p. 1409.

[78] The Automobile Insurance Act, L.Q. 1977, c. 68 and An Act to Establish the Régie de l'assurance automobile du Québec, L.Q. 1977, c. 67.

[79] The phrase has been used to cover a number of changes (some of which are not, strictly speaking, tort law changes) which affect the entitlement to and amount of compensation received by personal injury plaintiffs.

[80] See Atiyah, "No Fault Compensation," pp. 272-273. The two states that have repealed their threshold plans are Pennsylvania and Nevada. See the discussion in Chapter 11.

(a) Tort Reform in Ontario

There have been several important developments in the last fifteen years in relation to motor vehicle accident compensation in Ontario; some have been statutory, others have been common law developments. The overall impact of these developments has been to increase both the number of claimants entitled to tort compensation and to increase the amount of damage awards.

(i) Legislative Change

In 1973, the limitation periods in the Highway Traffic Act, Fatal Accidents Act and Trustee Act were increased from one to two years.[81]

In 1975, the Family Law Reform Act made it possible for a husband and wife to sue each other, and for children to sue their parents.[82] The Insurance Act and the Negligence Act were amended to accommodate these changes.[83] The Negligence Act amendments permitted contribution and indemnity between family members.[84]

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[81] The Highway Traffic Amendment Act, 1975 (No. 2), S.O. 1975, c. 37, s. 1; The Fatal Accidents Amendment Act, 1975, S.O. 1975, c. 38; The Trustee Amendment Act, 1975, S.O. 1975, c. 39.

[82] S.O. 1975, c. 41.

[83] S.O. 1975, c. 41, ss. 5, 7.

[84] S.O. 1975, c. 41, s. 7 (repealing the Negligence Act, R.S.O. 1970, c. 296, s. 2(4)).

In November 1977, the Judicature Act was amended to permit a successful plaintiff to recover prejudgment interest.[85] One clear objective of the amendment was to provide a defendant (or a defendant's insurer) with an incentive to resolve claims by payment at an early date. A less clear, but nevertheless reasonable objective, was to provide full compensation to the injured plaintiff who had been denied access to judgment or settlement proceeds until payment.

The Family Law Reform Act, 1978 (F.L.R.A.)[86] made a number of significant changes in the compensation rules. It repealed the Fatal Accidents Act and brought compensation in both fatal and non-fatal accident cases under the same statutory umbrella.[87] It expanded the statutory right to compensation by permitting relatives not entitled under the Fatal Accidents Act to claim for compensation.[88] The F.L.R.A. (and its successor, the Family Law Act, 1986 (F.L.A.)) permitted claims by the spouse, children, grandchildren, parents, grandparents,

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[85] The Judicature Amendment Act, 1977 (No. 2), S.O. 1977, c. 51.

[86] S.O. 1978, c. 2, s. 79, repealing R.S.O. 1970, c. 164; S.O. 1973, c. 16; S.O. 1975, c. 38. Compensation in fatal accident cases was provided for in Part V of the Family Law Reform Act, R.S.O. 1980, c. 152 (now the Family Law Act, 1986, S.O. 1986, c. 4).

[87] The Fatal Accidents Act provided for compensation on behalf of parents, children, etc.

[88] S.O. 1978, c. 2, s. 60; S.O. 1986, c. 4, s. 61. For a comprehensive analysis of the guidance, care and companionship claims permitted by s. 60 of the F.L.R.A. see Mason v. Peters (1982), 39 O.R. (2d) 27 (leave to appeal to the Supreme Court of Canada refused).

brothers and sisters of the deceased.[89] The F.L.R.A. provided for claims for compensation for the loss of guidance, care and companionship in bodily injury and fatal accident cases.

As of July 1, 1978, accident benefits, contained in Section B of the standard automobile policy, were increased.[90] From a cost standpoint, the most significant increase was in the disability benefit from $70 a week to $140 a week maximum. Medical, rehabilitation, death and funeral benefits were also increased at that time.

In 1980, the Rules of Practice were amended to establish a 2.5% discount rate to determine the present value of an award for future pecuniary loss. The present rule provides:

> The discount rate to be used in determining the amount of an award in respect of future pecuniary damages, to the extent that it reflects the difference between estimated investment and price inflation rates, is 2 1/2% per year.

Before the introduction of the 2.5% discount rate rule, future losses were commonly being discounted at 7%, and sometimes at a higher rate. The reduction of the discount rate to 2.5% has worked to increase claims costs in fatal accident cases, and in those cases where injuries sustained were severe enough to cause future losses (future care and loss of future income).

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[89] O. Reg. 1004/78, s. 1(1).

[90] S.O. 1984, c. 11.

In 1984, s. 129 of the Courts of Justice Act was amended to permit the court, with the consent of all affected parties, to order the defendant to pay all or part of the award for damages periodically on such terms as the court considers just; and to order that the award for damages be subject to future review and revision in such circumstances and on such terms as the court considers just.

This section of the Act clearly permits what are known as structured settlements, but only on a consensual basis. Beyond establishing a pattern of future periodic payments, a structured settlement has the additional advantage of avoiding what has come to be called "gross-up".

(ii) Common Law Developments

In 1973, the Ontario Court of Appeal in Boarelli v. Flannigan confirmed that in Ontario collateral benefits paid to a plaintiff are not to be deducted from the plaintiff's third party tort recovery. As the law now stands, income indemnity payments of any kind and whether from public or private sources will not be deducted from the plaintiff's award for damages.[91]

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[91] For a review of the law on collateral benefits, see T.J. Collier and R.A.D. Watt, "Deductibility of Collateral Benefits -- Double Recovery?" Paper prepared for the Personal Injury Damages: Current Law Under Attack, program of the Department of Education, Law Society of Upper Canada, May 24, 1986; also see K.D. Cooper-Stephenson and Iwan B. Saunders, Personal Injury Damages in Canada (Toronto: Carswell, 1981).

In 1978, the Supreme Court of Canada decided three personal injury cases which have become known as the Trilogy.[92] In Andrews v. Grand & Toy Alberta Ltd., a 21-year-old motorcyclist became a quadriplegic when he collided with a van driven by an employee of Grand & Toy. In Teno v. Arnold, a 4 1/2-year-old girl was hit by a car as she tried to cross the street after buying ice cream from a street vendor. Her injuries were so severe that she would require assistance to perform even basic tasks for the rest of her life. In Thornton v. Board of School Trustees, a 15 1/2-year-old boy was seriously hurt attempting a somersault off a springboard in his high school physical education class. He missed the landing mats and suffered injuries which made him a quadriplegic.

In considering the cases together, the Court responded to the need for clear and consistent principles to govern awards of damages in severe personal injury cases. In addition to formulating guidelines with respect to compensation for future care costs and loss of earnings capacity, the Court examined the purpose of awards for non-pecuniary damages. Compensation under this head of damages involves consideration of such factors as pain and suffering, lost amenities and lost expectation of life.

In Andrews, Mr. Justice Dickson stated that if an injured person is properly provided for in terms of future

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[92] Andrews v. Grand & Toy Alberta Ltd., [1978] 2 S.C.R. 229; Arnold v. Teno, [1978] 2 S.C.R. 287; Thornton, Tanner et al. v. Board of School Trustees of School District No. 57 et al., [1978] 2 S.C.R. 267. For a critical review of the Trilogy, see B. Feldthusen and K. McNair, "General Damages in Personal Injury Suits: The Supreme Court's Trilogy," U. of T. L.J. 28 (1978): 381.

care, large amounts should not be awarded for non-pecuniary loss. Non-pecuniary damages should serve the function of making life more "endurable" for the disabled person, above and beyond awards directly related to the injuries involved.[93]

The Court held that there should be a "rough upper parameter" in such awards, and that amounts should not vary greatly from one part of the country to the other. The amount awarded in Andrews, Teno and Thornton was $100,000. Although the Court approved consideration of individual cases ("in recognition of the inevitable differences in injuries, the situation of the victim, and changing economic conditions"),[94] $100,000 was fixed as the upper limit for non-pecuniary loss, save in exceptional circumstances.[95]

In Lindal v. Lindal, the Supreme Court of Canada confirmed that the upper limit was to be adjusted for

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[93] [1978] 2 S.C.R. 229 at 261-62. The Court took a functional approach to the award of non-pecuniary damages; also, see A.I. Ogus, "Damages for Lost Amenities: For a Foot, a Feeling or a Function?" Mod. L. Rev. 35, no. 1 (1972): 1.

[94] [1978] 2 S.C.R. 229 at 263, per Dickson, J.

[95] The Court's indication that higher awards may be given in exceptional circumstances has led to the challenges to the Trilogy cap in subsequent cases. The British Columbia Supreme Court awarded a severely brain damaged plaintiff $135,000 in Lindal v. Lindal, [1978] 4 W.W.R. 592 rev'd in part 115 D.L.R. (3d) 745; aff'd [1981] 2 S.C.R. 629, but the amount was reduced to $100,000 on appeal. A further appeal to the Supreme Court of Canada was dismissed. The case demonstrated that in practice it would be very difficult to establish a case for exceeding the limit on the basis of severity of injuries.

inflation and fixed the date of its judgment in the Trilogy as the date from which the effect of inflation should be measured. The 1978 cap of $100,000 is equal to approximately $195,000 in 1987 dollars.

When the Trilogy cases were decided in 1978, no allowance was made for gross-up, that is the income tax liability on the investment income generated by the lump sum award for future care. The Supreme Court of Canada had recognized the need for gross-up in fatal accident cases where damages are assessed on the basis of a deceased's after-tax income (as compared to personal injury cases where the victim is awarded damages for loss of future income on a pre-tax basis).[96]

Then, in Fenn v. City of Peterborough[97] the Ontario Court of Appeal rejected the proposition that the Trilogy cases foreclosed the possibility of awarding an extra amount of money to pay the tax on investment income from a lump sum award for future care. The Court found that claims for an allowance for tax failed in Andrews, Teno and Thornton "for want of adequate proof". The evidence in Fenn was similarly insufficient, and the Court decided that it could not assess an amount for gross-up. But subsequent cases in Ontario have followed Fenn in principle and gross-up has become commonplace for awards for future care in personal injury cases.[98]

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[96] Keizer v. Hanna, [1978] 2 S.C.R. 342.

[97] (1979), 25 O.R. (2d) 399.

[98] Although Fenn has been followed in Ontario on principle, the appropriate amount to award for gross-up is still a contentious issue. The amount commonly awarded is 35%, but in the highly publicized case of McErlean v.

The situation is quite different in other provinces. Courts in both Manitoba and British Columbia have rejected the decision in Fenn and have refused to award tax gross-ups in some cases.[99]

From this summary of recent statutory and common law developments, it will be readily seen that the number of people entitled by law to motor vehicle accident compensation has increased and new rights to compensation have been created.

The cumulative impact of all of these advances in tort law is that more potential claimants per accident have access to increased rights of compensation in Ontario. The increase in damage awards was illustrated by Professor Rea in a recent recalculation of the damage award in Andrews v. Grand & Toy (one of the "Trilogy"). Having regard to the legislative and judicial changes in the method of assessing damages, Rea estimated that the 1978 award of $896,147 would be increased to $3,731,871 in 1986. This is an increase of 316% during a period when the price increase due to inflation was 84%. In constant

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Sarel and The Corporation of the City of Brampton (1985), 32 C.C.L.T. 199, the Ontario High Court awarded 153%. The Court of Appeal (in a judgment released September 10, 1987) overturned this decision and found that the gross-up should have been one-half the amount awarded.

[99]MacDonald v. Alderson, [1982] 3 W.W.R. 385 (Man. C.A.); Leischner v. West Kootenay Power & Light Co. Ltd., [1986] 3 W.W.R. 97 (B.C.C.A.); Scarff v. Wilson (1987), 39 C.C.L.T. 20 (B.C.S.C.). But see Watkins v. Olafson (1987), 40 C.C.L.T. 229 (Man. C.A.).

dollar terms, the award increased by 226%.[100] In light of examples like this, it is perhaps not surprising that the increasing size of tort awards became an issue for this Inquiry. The combination of higher awards and more claimants has led to increased costs for the automobile insurance system, a system funded by premiums paid by Ontario drivers.

(b) Tort Reform in the United States

The direction of tort reform in the United States has been somewhat different than in Ontario. Prompted by what was viewed as a crisis in liability insurance, more than two-thirds of the state legislatures in the United States have passed various reform measures, aimed at curtailing rights to compensation and to the amount of recovery.[101] These measures have not been specifically directed at tort actions arising out of motor vehicle accidents. Municipal liability and medical malpractice cases have been the chief focus of tort reform, although some measures apply more broadly. Chief among the legislative changes in the United States have been:

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[100] Rea, "Economic Perspectives on the Liability Insurance Crisis," Law Society of Upper Canada Special Lectures (March 1987).

[101] For a summary, see Business Insurance, (August 18, 1986). The survey conducted by Business Insurance indicated that 34 states had enacted tort reform measures to reduce liability exposures and to make insurance more available and affordable.

(a) a legislative upper limit or "cap" on damages for non-pecuniary loss;[102]

(b) abolition or modification of the common law doctrine of joint and several liability whereby a defendant even 1% at fault is legally responsible for the entire damage award;[103]

(c) legislation encouraging or requiring structured settlements in some personal injury cases;[104]

(d) legislation limiting punitive damage awards;[105] and

(e) legislation abolishing or modifying the collateral source rule, whereby a plaintiff is not obligated to reduce his tort award by any collateral source income that he receives.[106]

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[102] In some states, the cap on non-pecuniary damages has been restricted to medical malpractice actions only. In many states, the cap is particularly high, for example, $1,000,000 in West Virginia, Wisconsin and South Dakota (all restricted to medical malpractice cases) and $400,000 in Minnesota (applicable generally).

[103] The rule, in any event, has limited application in motor vehicle accident cases.

[104] In Ontario, structured settlements may be ordered by the court on the consent of the parties. See Courts of Justice Act, S.O. 1984, c. 11, s. 129.

[105] Punitive damage awards again are of little relevance in motor vehicle accident cases.

[106] This is the Ontario rule. See Boarelli v. Flannigan (1973), 36 D.L.R. (3d) 4 (Ont. C.A.). The collateral source rule is discussed in some detail in Chapter 10. According to Business Insurance, footnote 101, 10 states

(c) The Canadian and American Tort Systems

The call for tort reform in the United States to restrict personal injury compensation has prompted similar cries in Canada. Yet many of the reform measures urged in American state legislatures are already part of the tort system of this province. Many of those to whom I spoke in my travels in the United States looked upon the Ontario system with envy. The situation was best summed up by one American newspaper in which the following appeared: "Perhaps most significant every restriction that insurers seek to enact in the U.S. has long been the law in the Canadian province of Ontario."[107]

We should not then be oblivious to the important differences that affect the way in which accident victims are compensated in this province and in the United States. Several of these differences affect the delivery of motor vehicle accident compensation.[108] Among the major differences between the Canadian (or Ontario) and American systems that affect the cost, availability, and quantum of compensation for persons injured in motor vehicle accidents are the following:

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have passed legislation to modify the collateral source rule, so that payments made to plaintiffs from other sources such as medical insurance may be introduced as evidence and/or used to reduce an award.

[107] Oakland Tribune (May 13, 1986).

[108] The differences in the Canadian and U.S. tort systems are discussed in Michael J. Trebilcock, The Insurance-Deterrence Dilemma of Modern Tort Law, a paper originally prepared for the Ontario Task Force on Insurance (see the second draft of the paper, January 1987).

(a) American motor vehicle accident cases are almost invariably heard by juries which arguably injects more uncertainty into the system. Even where cases are tried by jury in Ontario, the reasonableness of the award is determined by the Court of Appeal against standards assessed by trial judges.

(b) Personal injury lawyers in the United States are paid by a contingent fee, that is a percentage of the damage award. It is thought by some that contingent fees lead both to more speculative actions being brought and to the inflation of damage awards by juries. The contingent fee is prohibited in Ontario. However, the negligence bar routinely charges claimants on a modified contingent fee basis.[109]

(c) As I have indicated, awards for non-pecuniary damages in Canada are subject to a relatively modest judicially imposed cap which, although increasing with inflation, is still less than $200,000. In most American states, there is no upper limit on the amount of this head of damages. Even in the few states where there is a legislatively imposed cap on these awards in motor vehicle accident cases, the cap has been set at $250,000 or more.[110] Damages for pain and

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[109] See Chapter 9.

[110] The states with a cap on non-pecuniary damages applicable to motor vehicle cases include Alaska ($500,000), Colorado ($250,000 but damages up to $500,000

suffering are a major component of United States personal injury awards.

(d) Minimum mandatory third party liability coverage in Ontario is $200,000. In most American states, mandatory third party limits have remained very low, invariably in the range of $50,000 or less. For example, New York State has had $10,000/$20,000 limits in place for thirty years.[111] As a result, the risk of an unsatisfied tort judgment is much higher in the United States than in this province.

(e) In Ontario, O.H.I.P. provides medical and hospital coverage to virtually every citizen. There is no comparable universal government subsidized health care program in the United States.

(f) In civil actions in Ontario, the winning party normally is awarded "costs" against the losing party. In the United States each side bears its own costs. The Ontario rule discourages speculative actions; some would argue it discourages even legitimate actions.

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at the court's discretion), Florida ($450,000 but declared unconstitutional by the Supreme Court of Florida. See Smith et al. v. Department of Insurance, April 1987), Hawaii ($375,000), Maryland ($350,000), Minnesota ($400,000), New Hampshire ($875,000). See Business Insurance (August 18, 1986).

[111] I.B.C., Facts Book, 1986.

It is, in my view, important to recognize that these differences exist.[112] The question as to whether the tort system should be preserved for the compensation of motor vehicle accident victims in Ontario must be assessed in light of the way the system operates in this province. I think it fair to say that many of the concerns expressed about the American tort system do not apply to Ontario.

(d) The Future of the Tort System for Motor Vehicle Accident Compensation in Ontario

I have sketched the evolution of the tort system of compensation. What remains to be considered is whether access to tort law should remain part of the system by which we compensate motor vehicle accident victims in Ontario. This requires an assessment as to whether tort

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[112] There are other differences between the Canadian and U.S. tort systems discussed by Trebilcock, The Insurance-Deterrence Dilemma, e.g.

(1) Punitive damages are rarely awarded by Canadian courts but can be an important element of U.S. damage awards.

(2) The rules for class action suits are more permissive in the United States.

(3) The Supreme Court of Canada is the final appellate court for all types of cases including tort actions. It can, therefore, provide a measure of uniformity across the various provinces. The U.S. Supreme Court does not hear appeals on matters of purely state law which include most aspects of tort law, thereby leaving open the possibility of diversity of principles in the various states.

(4) The movement from negligence to strict liability in product liability law in the U.S. has not occurred in Ontario.

law still serves any social purpose. It also requires an assessment of the social and economic costs of maintaining or modifying the present system and of the benefits and costs of choosing an alternative compensation system. These issues are addressed in Chapters 10, 11 and 12.

Unfortunately, the debate over the continued existence of the tort system in Ontario has taken place largely without the benefit of empirical evidence. In my opinion, to make an informed assessment of the tort system, it is important to determine answers to questions such as the following: Who is being compensated under the present system and from what sources? Who is not being compensated? What amounts are being paid for each of the components of a tort award? What are the legal and administrative costs associated with maintaining the tort system? What collateral sources of income support do Ontario drivers have if injured? Does the tort system deter unsafe driving or provide incentives to safe driving? I sought answers to these and related questions. I have considered existing research and commissioned research in areas requiring further study. I have also sought the views and opinions of the public, of those non-experts for whose benefit the motor vehicle compensation insurance system exists. As is evident in what follows, my own views have benefitted greatly from this research and from the opinions of others.

CHAPTER 9

CARS AND THE COURTS

A. LITIGATED CLAIMS

In the absence of a pure no fault system of compensation, there will continue to be some third party litigation. I recognize that my mandate is limited to motor vehicle accident cases; nevertheless, some comment on our system of litigating personal injury cases is appropriate. My comments will relate to third party claims.

This chapter deals with those relatively few claims in which an action is commenced and pursued. In general, the system should be structured to encourage early, as opposed to last minute, settlements. The system should be cost effective. Having those general goals in mind, these problem areas can be identified:

(a) Pleadings

In motor vehicle accident litigation, pleadings are unnecessarily complex and virtually of no help. All that should be required is an identification of the accident giving rise to the claim and the amount claimed; this is needed because of policy limits considerations. On balance, I see no real benefit to pleadings particularizing negligence. The statement of claim should set out the damages claimed for both economic and non-economic loss for each plaintiff and a statement as to the nature of the plaintiff's injuries. The statement of

defence should briefly set out the defendant's position on both liability and damages. Motor vehicle accident pleadings have become programmed boiler plate. Can it be said that any litigant is really informed as to the real issues in an action arising from a motor vehicle accident, after reading cosmic allegations such as "he was an incompetent driver lacking in reasonable skill and self-command and ought not to have been operating a motor vehicle under the circumstances" or, for those interested in history, if not pleadings, "he had the last clear chance of avoiding the accident but failed to do so." I reject the argument that a jury's verdict must be tested against the allegations of negligence included in a statement of claim or statement of defence and counterclaim. Examinations for discovery will identify what a defendant is alleged to have done wrong and will allow all parties to identify the real issues in the action. It is surprising how often unsupported, irrelevant and sometimes absurd allegations of negligence go to inflame an opposite party who has occasion to be served with or given a copy of a pleading. Pleadings, as they are now structured in motor vehicle accident cases, are not much more than a make-work program attended to in most law offices by anyone but a lawyer.

Alternatively, if we are to continue to encumber pleadings with unnecessary detail, trial judges should be given specific authority to impose cost penalties on solicitors making unsupported allegations in pleadings. The client should not bear the burden as the client has absolutely nothing to do (in the vast majority of cases) with the pleadings.

(b) Pre-trials

All cases should be pre-tried and not placed on a trial list until certified as ready by the pre-trial judge or, in the absence of the pre-trial judge, another judge of the court. I fully endorse the recommendation of the Ontario Courts Inquiry that the pre-trial assume a position of greater prominence in the overall process. We have come to recognize, or perhaps admit, that one of the dominant purposes of a pre-trial is to promote settlement. A secondary purpose is to consider internal organization of the trial with a view to saving trial time.

In the motor vehicle accident context, when damages are in issue, pre-trial documentation should include:

(1) all medical reports of any doctor whose evidence will be tendered at trial, either in the form of viva voce evidence or by the filing of a medical report;

(2) any other experts' reports to be relied upon; and

(3) a breakdown of the party's position with respect to all aspects of economic loss; this would include special damages, loss of income to trial, future loss of income, and future care costs.

The parties should attend the pre-trial, where possible. If a defendant is insured, it would seem impractical to require a defendant to attend the pre-trial, unless policy limits are a relevant issue. Otherwise the parties should attend where possible. The presence of the parties will enhance the prospects of

settlement and perhaps encourage counsel actually handling the file to appear in person at the pre-trial.

If at the time of the pre-trial conference either party requires a further medical examination, the issue of whether the action should be deferred on that account is a matter of discretion for the pre-trial judge and the ultimate discretion of the trial judge.

(c) Medical and Other Experts' Reports

There is a lack of consistency in the way medical and other experts' reports are dealt with both before and at trial. Before proceeding to recommended solutions, I should briefly identify what I think the objectives should be. First, medical and other experts' reports should be produced to avoid unfairness, that is, trial or even settlement by ambush. Second, the production and disclosure of experts' reports will enhance prospects of a fair settlement. That objective suggests that full and relatively early production and disclosure should be required. Third, from a cost and convenience standpoint, it is desirable that medical and other experts where practicable give their evidence by way of report, rather than attending at trial.

Having those objectives in mind, I propose to briefly consider the provisions of section 52 of the Evidence Act (medical reports and medical evidence); Rule 50.5 (pre-trial production of experts' reports, including medical reports); Rule 53.03 (the production of a summary of an expert's proposed testimony); and section 118 of the

Courts of Justice Act[1] and Rule 33.04 (independent medical or dental examinations; the production of medical or dental reports for the independent medical examination and the production of the medical report of the medical or dental examiner).

Section 52 of the Ontario Evidence Act provides[2]

> 52. (1) Any medical report obtained by or prepared for a party to an action and signed by a legally qualified medical practitioner licensed to practice in any part of Canada is, with the leave of the court and after at least seven days notice has been given to all other parties, admissible in evidence in the action.
>
> (2) Unless otherwise ordered by the court, a party to an action is entitled to obtain the production for inspection of any report of which notice has been given under subsection (1) within five days after giving notice ot produce the report.
>
> (3) Except by leave of the judge presiding at the trial, a legally qualified medical practitioner who has medically examined any party to the action shall not give evidence at the trial touching upon such examination unless a report thereof has been given to all other parties in accordance with subsection (1).
>
> (4) Where a legally qualified practitioner has been required to give evidence viva voce in an action and the court is of opinion that the evidence could have been produced as effectively by way of a medical report, the court may order the party that required the attendance of the medical practitioner to pay as costs therefore such sum as it considers appropriate.

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[1] S.O. 1984, c. 11.

[2] Evidence Act, R.S.O. 1980, c. 145.

The provisions of section 52 are somewhat convoluted. section 52 deals with notice, the production of medical reports, the use of medical reports at trial and the conditions precedent to a medical practitioner's right to give evidence at trial. It seems clear to me that the legislative intent was to reduce the cost of litigation by permitting medical evidence to be given by report. Filing of medical reports, rather than calling a doctor to give viva voce evidence, was not only permitted, but encouraged. Section 52(4) imposes potential cost penalties in circumstances where a doctor has given viva voce evidence and where the trial judge has concluded the evidence could have been given "as effectively" by filing a report.

The section 52 route to disclosure and production of medical reports is anything but direct. Section 52(1) deals with the admissibility of reports of medical practitioners and the seven days' notice required as a condition precedent to the admissibility of a medical practitioner's report. Section 52(2) deals with the production for inspection by an opposite party who has received notice of the medical reports that are referred to in section 52(1). Section 52(3) imposes restrictions on a party's right to call a medical practitioner to give viva voce evidence at trial.

The disclosure established by section 52 of the Evidence Act is late (seven days before trial) and pertains only to medical practitioners whose reports are to be filed at trial or doctors who will be called to give viva voce evidence at trial.

Section 52 applies only to medical practitioners, not for example, to dentists and other health professionals. In the case of other experts, a report must be provided 10 days before trial setting out the substance of the expert's testimony (see Rule 53.03).

The provisions of section 118 of the Courts of Justice Act and Rule 33 provide a somewhat circuitous route to production and disclosure of a plaintiff's medical reports. If a defendant has by order or on consent secured a defence medical (dental) examination, Rule 33.04 requires that the plaintiff provide the defendant with "any report made by a medical examiner who has treated or examined" the plaintiff. The production must be made seven days before the defendant's medical examination. The plaintiff does not have to produce reports of doctors unless they have treated or examined the plaintiff and the plaintiff does not have to produce medical reports of doctors, whom the plaintiff undertakes not to call as witnesses at trial. It should be noted that the term medical practitioners as referred to in section 118 of the Judicature Act and in Rule 33 includes dentists.

The pre-trial will also trigger production of medical reports. Rule 50.05 provides:

> 50.05 All documents intended to be used at the hearing that may be of assistance in achieving the purposes of a pre-trial conference, such as medical reports and reports of experts, shall be made available to the pre-trial conference judge or officer.

In practice, Rule 50.05 and the pre-trial itself provide the earliest required production of medical

reports unless the defence has arranged its own medical examination. Rule 50.05, however, excludes medical reports not being relied upon, with the result that not all of the doctors' reports have to be produced. This can occur and, in my experience, has occurred in circumstances where a party intends to rely upon some, but not all of the doctors' reports. Further, Rule 50.05 only requires that medical reports, etc., be made available to the pre-trial judge.

The dominant goals, as earlier identified, should be to promote fair trials, early settlement and reduce the cost of litigation. The first two objectives are best served by the relatively early and full disclosure of all experts' reports. The cost objective will be best served if as much evidence as is reasonable is given by way of report.

The production, disclosure and use of experts' reports should be re-examined with a view to promoting early settlement and consistency and with a view to reducing the costs of litigation. This will require amendments to the Evidence Act and the Rules. I have the following recommendations with respect to medical and expert evidence:

(a) Given counsel's right to cross-examine, reports of all health professionals should be brought within the ambit of section 52 of the Evidence Act. I think of dentists, chiropractors, psychologists, physiotherapists and rehabilitators in particular. I can see no reason why the admissibility of their reports depends on consent. If counsel wishes to cross-examine any

health professional, counsel may exercise that right, subject to the lurking sanction in the form of the cost provisions of section 52(4).

(b) Rule 53.02(1) should be resorted to more frequently. That Rule permits the evidence of a witness to be given by affidavit. For example, hospital records are brought to court by the hospital librarian, who may sit patiently for hours and then give evidence for seconds. If that kind of documentation is not to be filed on consent it should, in most instances, be proved by affidavit. There are many other examples.

(c) The production of medical (and other experts') reports should be required within seven days of counsel's receipt of those reports. Alternatively, the pre-trial should be the focal point for production of medical and other experts' reports. All such reports should be produced seven days before the pre-trial. Rule 50.05 and section 52 of the Evidence Act should be both expanded and tightened. It should be made clear that full production and disclosure of medical and other experts' reports must be made for pre-trial purposes. Rule 50.05 provides for limited disclosure for pre-trial purposes, as stated. An effective pre-trial cannot be conducted if the production of experts' reports is incomplete, or if only the pre-trial judge is given copies of the parties' medical and other experts' reports.

(d) Section 52 of the Evidence Act (as expanded to include other health professionals) should be made less cumbersome. Though most counsel routinely produce medical reports, not all do. The cumbersome provisions of section 52(2) require an opposite party to seek production of some or all of the medical reports referred to in the notice given under subsection (1). Surely a simpler route to disclosure would be to require counsel intending to file a medical report simply to produce it. Similarly counsel intending to call a doctor as a witness should be required to produce all medical reports of that doctor. The same would apply to other health professionals if brought within section 52 of the Evidence Act.

(e) As earlier stated, pre-trial disclosure, not disclosure seven days before trial, should be required. It should be made clear that doctors who have medically examined any party (section 52(3)) and doctors who are involved as consultants only, are subject to the same rules with respect both to medical reports and the doctor's right to give viva voce evidence at trial. There is now a conflict between subsections 52(1) and 52(3) in that regard. If a doctor's evidence is relevant and otherwise admissible, the evidence should be permitted to be given either in the form of the filing of a medical report, or by calling the doctor to give viva voce evidence. There is a virtually absolute right of cross-examination which would control abuses in resort to the section 52(1) evidentiary route.

(f) The trial judge should have the discretion to permit an expert's report to be filed as an exhibit in jury and non-jury trials, even if the expert will be called to give viva voce testimony at trial. As matters now stand, if a doctor is called to give viva voce evidence, the doctor's medical report or reports cannot be filed except on consent.[3] In non-jury cases, counsel consistently consent to the trial judge hearing the medical witness as well as to the witness's report being given to the trial judge, and often filed as an exhibit. This does not happen with frequency in jury actions. In cases where the interest of justice requires it, a trial judge can direct that a doctor's medical/legal report not be filed as an exhibit.

(g) In jury cases, trial judges, in their discretion, should be permitted to express an opinion to the jury as to a range of compensation for both pecuniary and non-pecuniary damages. This will require an amendment to the Courts of Justice Act because of the Court of Appeal's decisions in Gray v. Alanco Developments Ltd.,[4] and Howes v. Crosby.[5]

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[3] See Ferraro v. Lee (1974), 2 O.R. (2d) 417.

[4] 61 D.L.R. (2d) 652, [1967] 1 O.R. 597 (Ont. C.A.).

[5] (1984), 45 O.R. (2d) 449, 29 C.C.L.T. 60, 6 D.L.R. (4th) 698 (Ont. C.A.).

(d) Costs

It is virtually common ground that costs of litigation must be brought under control. How this may be done is beyond the scope of this Report. Moreover, it is clear that there are few instances where separate rules can be established to apply to motor vehicle or personal injury litigation in isolation. Nevertheless, the issue of costs, particularly as related to motor vehicle accident litigation, requires some comment.

The Ontario Courts Inquiry's recommendation as to expanding the Provincial Court (Civil Division) monetary jurisdiction to $10,000 should have a significant impact on costs in smaller motor vehicle-related bodily injury cases. The recommendation of the Ontario Courts Inquiry on costs in the Provincial Court (Civil Division) is that no costs in excess of assessable disbursements be paid. It might well be said that this recommendation will not lower costs, but simply reallocate costs in those cases where claimants are represented by counsel. If successful, instead of the defendant paying what we now characterize as party-and-party costs, thereby lowering the plaintiff's solicitor and client cost obligation, injured plaintiffs will be required to pay counsel out of their own resources. I think it is likely that there will be more than a reallocation of costs in the Provincial Court. Plaintiffs may well decide to make claims without the assistance of a lawyer in that Court. I will refer later to methods by which this can be encouraged.

Even if the implementation of the Ontario Courts Inquiry's recommendation results in nothing more than a reallocation of costs in the Provincial Court, insurance

premiums will be lowered because insurers will not be required to pay costs other than disbursements to a successful plaintiff.

The Inquiry's Claims Survey revealed that party-and-party costs paid to claimants in cases where judgments or settlements were between $1 and $10,000 amounted to 11.3% of the claims dollar. These costs will not be entirely eliminated in that, for example, costs for medical/legal reports will continue to be paid. Nevertheless, the impact of the recommendation of the Ontario Courts Inquiry as to costs in the Provincial Court (Civil Division), will be significant. Inquiry Claims Survey data suggest that a 3% savings may be effected.[6] It remains to be seen what stance insurers will take in negotiating settlement of claims which are to be dealt with in the Provincial Courts or claims in any court which will result in an assessment within the monetary jurisdiction of the Provincial Court. I speculate that if insurers make any offer of costs above reasonable disbursements, costs will be dealt with on a much more modest basis than is the case now.

Litigants in the Provincial Court (Civil Division) should be encouraged to represent themselves. This has been dealt with in the Report of the Ontario Courts Inquiry. I recommend that all Provincial Courts (Civil Division) have assigned duty counsel to assist all those who require help at the pre-trial and at trial. Duty counsel at the pre-trial should ensure that plaintiffs, in

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[6] This estimate comes from the actuarial analysis of Inquiry Claims Survey data which includes party-and-party costs paid in all claims surveyed and for these purposes, particularly those claims between $1 and $10,000.

particular, have filed offers to settle and that required evidence (such as medical/legal reports) is available. Medical evidence in the Provincial Court should almost always be in the form of a report, unless leave is granted to have a medical practitioner give viva voce evidence.

I am reluctant to enter the embryonic contingent fee debate, as I am aware that the issue is now being considered by a Committee of the Law Society of Upper Canada. I cannot, however, resist noting that we cannot afford to be too sanctimonious about the contingent fee issue as it relates to personal injury litigation. The personal injury bar is not unblemished by any contact with the evils of the contingent fee. I tend to think that these evils are not as significant as many seem to think. Any debate about contingent fees should take into account the fact that contingent fees are already used in personal injury litigation. Costs now paid by insurers to plaintiff's counsel are contingent in the sense that the amount of costs paid is most often established as a percentage of the total settlement. The lawyer's solicitor and client account to the personal injury plaintiff (the lawyer's fee net of costs paid by the insurer) is usually calculated on a percentage basis often having nothing to do with the work done or the value of the service, except to the extent that the amount of recovery is in itself evidence of the value of the service.

Fees in a typical personal injury settlement are often dealt with as follows: if an insurer and plaintiff's counsel agree to settle a personal injury claim for $30,000, the settlement package will involve the insurer paying the agreed $30,000 plus approximately $4,000 and

perhaps taxable disbursements in costs. The taxable disbursements will include the cost of medical/legal reports. In some cases, the costs agreed to will be more than $4,000. In other cases, costs will be less than $4,000. I think $4,000 is a reasonable estimate of the costs in the example cited. Plaintiff's counsel will typically submit an account to the plaintiff in an amount between $7,000 (the costs paid by the insurer plus 10% of the settlement) and $8,500 (the costs paid by the insurer, plus 15% of the settlement). In this example, the contingency is the amount of the recovery, in that it is still open to plaintiff's counsel to charge on a time basis, etc. if the action commenced for the injured plaintiff is unsuccessful. The final result in personal injury litigation is that the normal fee structure is contingent if recovery is effected, and traditional if it is not.

The modified contingent fee structure used in Ontario personal injury litigation is somewhat different than the typical American contingent fee arrangement. First, the American attorney's right to any fee is dependant upon success. Second, in Ontario insurers often pay between 10 and 15% in costs, however far along the road to trial the litigation has progressed at the time of settlement; in the United States insurers pay no party-and-party costs in most cases and the American attorney's contingent fee entitlement usually increases as steps towards trial or appeal are completed. Although I continue to be mystified why insurers in Ontario routinely pay 10-15% in party-and-party costs at virtually all stages of settlement negotiations, it is nevertheless clear that insurers' objective is to provide a very specific incentive for early settlement.

Serious consideration should be given at the trial level to making orders in the form of directions to the assessment officer with respect to disbursements. The trial judge is in the best position at the conclusion of a trial to consider the legitimacy of disbursements such as fees paid for medical, legal and actuarial reports. If appropriate, the trial judge can fix "part of" the costs of the party entitled to costs.[7]

I am told by assessment officers that to achieve some consistency, expert witnesses who attend trial are often dealt with for party-and-party costs purposes on the basis of the same hourly rate as is established for counsel. By and large, I think assessment officers can look after witness fees at trial. In some instances, the trial judge is in a better position to deal with costs related to reports that sometimes seem to me to be exorbitant. Paying $3,500 for an actuarial report to establish a $7,000 future loss, for example, offends my sense of the law of reasonable proportions.

If the recommendations of the Ontario Courts Inquiry are implemented concerning the Provincial Court (Civil Division), as I hope they are, some control on solicitor and client fees in that Court may be desirable. I recommend that the government and the Law Society of Upper Canada explore establishing some threshold upper limit on a lawyer's solicitor and client fee entitlement, at least in the Provincial Court where all legal fees will be paid by the claimant directly. The upper limit could be expressed in percentage terms (a percentage of the

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[7]Rule 57.01(3).

settlement). For example, if 15% was reasonable, a lawyer would be precluded from extracting more than 15% of a personal injury judgment or settlement from the injured client without having the solicitor and client account assessed. The assessment safety valve is necessary as there will undoubtedly be cases of complexity where an arbitrarily established upper fee limit would be both unfair and unreasonable. If we were to proceed to a full contingent fee system, the total solicitor and client fee would be determined by the contingent fee agreement and any regulation of its terms.

(e) Offers to Settle

I endorse the existing emphasis established by the Rules of Civil Procedure on offers to settle, and would only add that additional emphasis should be placed on requiring plaintiffs in particular to make a settlement offer. It is the plaintiff who is seeking damages. The party from whom damages are sought is entitled to know what the plaintiff wants. The plaintiff should be required to make a settlement offer within 7 to 10 days after a pre-trial. There may be cases where that is impractical; I do not envisage rigid requirements. However, I think that reasonable settlements would be promoted and accelerated were the plaintiff required to make a settlement offer at least at the time when the plaintiff, through counsel, has asserted a readiness for trial. If the plaintiff is unable to determine what his or her settlement position is at that point, one would think the case is not ready for trial.

The failure of a successful party to make a settlement offer should be among those factors considered by the trial judge when costs are dealt with. Rule 57.01 should

be amended to add this to the list of factors to be considered. The timing of settlement offers is already dealt with by the Rules. More emphasis should be placed on the existence of settlement offers.

B. MOTOR VEHICLE ACCIDENTS AND THE COURTS

The extent to which the courts are burdened with motor vehicle accident litigation is presented by some as a factor supporting the creation of a no fault or, as the Ontario Task Force on Insurance puts it, a "no tort system of compensation for motor vehicle accident-related injuries".

Motor vehicle accidents do not seem to place an undue burden on the courts, but even if motor vehicle accident cases did result in trial lists being clogged, it seems to me the court system, not the tort system, should be the primary focus of reform.[8] Put another way, any move to a different motor vehicle accident compensation system, or any decision to leave the present system wholly or partially intact should not, in my view, be based upon court list congestion.

Nevertheless, the issue of the extent to which court time is consumed by motor vehicle accident litigation deserves to be considered. I know I am on safe ground in stating that most trial judges acknowledge that the vast majority of motor vehicle accident cases (that is, cases on trial lists) are concluded by settlement, not trial. I would estimate that I have tried four or five murder cases for every motor vehicle case that has come before me and

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[8] In 1986, the Attorney General established the Ontario Courts Inquiry. Its recommendations are being considered.

proceeded to judgment. My experience is not unique among Supreme Court judges.

In dealing with the court congestion issue, I chose not to examine Provincial Court (Civil Division) records for two reasons. First, the data are either non-existent or not particularly helpful; second, the Report of the Ontario Courts Inquiry recommended that the jurisdiction of the Provincial Court (Civil Division) be increased to $10,000, thereby dramatically reducing the significance of existing records.

The raw material for motor vehicle accident litigation comes from motor vehicle accident claims. In any analysis of the manner in which motor vehicle accident-related claims are disposed of, I think it is sensible to start with the claim itself.

Table 9.1 sets out the number of motor vehicle claims made, actions commenced, actions set down for trial, trials and judgments from 1982 through 1985. The number of bodily injury claims is set forth in brackets for each year under the total number of motor vehicle accident claims for that period.

Actions are sometimes commenced to ensure that the two-year Highway Traffic Act limitation period is not missed; because of the limitation period lawyers engaged in personal injury litigation often adopt a "sue now, negotiate later" stance. It follows that the commencement of an action is not reliable evidence of a breakdown in settlement negotiations. An action may be started before settlement discussions begin. In result, the number of actions started is not evidence of the breakdown of settlement negotiations.

TABLE 9.1

PROGRESSION OF MOTOR VEHICLE ACCIDENT-RELATED CLAIMS*

YEAR	CLAIMS** MADE	ACTIONS COMMENCED	ACTIONS SET DOWN FOR TRIAL	TRIALS	JUDGMENTS
1982	209,355 (30,919)	18,224	3,341	1,204	1,083
1983	194,753 (32,021)	17,643	5,296	1,226	1,041
1984	219,948 (38,184)	16,011	5,427	1,095	920
1985	232,207 (42,074)	16,842	5,583	858	711
TOTALS	856,263 (143,198)	68,720	19,647	4,383	3,755

* Includes both Supreme and District Courts, jury and non-jury trials.

** Number of third party liability claims reported in the I.B.C. Green Book. The number in parentheses refers to bodily injury claims.

It is readily apparent that the vast majority of claims are property damage, not bodily injury claims. Most property damage claims are resolved by insurers through resort to the intercompany settlement agreement (the fault chart). The quantum of loss is rarely a problem in a property damage claim dealt with in or out of court, according to information I have received both from insurers and members of the Bar involved in that kind of claim. There are, of course, some notable exceptions; on balance, establishing the amount of property damage is not a problem.

The general flow of claims to resolution by settlement or trial is more important than an analysis of the data in any one year. 1985's trials and judgments for the most part, do not come from 1985's claims or from actions started in 1985. What is important is the disposition rate of the system by settlement or by trial at least when looked at over a reasonable timeframe. Looking at the 1982 to 1985 time period was, in my view, sufficient. 1986 data were not available.

Although the number of bodily injury claims has increased from 30,919 in 1982 to 42,074 in 1985, the number of actions commenced has declined from 18,224 to 16,842 over the same period. It would appear that although information received from insurers suggests that more claimants are represented by lawyers than ever before, the number of claims settled before the commencement of an action has increased, albeit not significantly. The number of actions set down for trial has remained relatively stable from 1983 through 1985. I suspect (I put it no higher than a suspicion) that the reason substantially fewer cases were set down for trial in 1983 than in 1982, 1984, or 1985 was the recession which provided an incentive for the early resolution of motor vehicle accident-related disputes.

Looked at on an aggregate basis over the entire period dealt with in Table 9.1 (1982-1985), certain conclusions are evident. They are:

(1) the vast majority of all claims are resolved without any action being commenced;
(2) actions were commenced in less than 50% of the bodily injury claims;

(3) even when an action was commenced, more than two-thirds of those actions were resolved before the action was set down for trial. A significant majority of actions commenced involve bodily injury claims, not property damage claims. That is not to say there may not be elements of property damage loss involved in the claim; however, the dominant issue is the bodily injury claim; and

(4) between 2% and 3% of bodily injury claims go to trial. It is difficult to be more exact because some of the trials which are recorded in Table 9.1 would have involved property damage claims, not bodily injury claims.

It should be noted that the data contained in Table 9.1 do not capture the number of cases proceeding to examination for discovery or the number of cases which were pre-tried. Most actions which are set down for trial would have been actions in which examinations for discovery had been held. Almost all actions which were tried would have been pre-tried. Although pre-trials are not compulsory, few cases proceed to trial without being pre-tried. Data are not available as to the time and expense involved in conducting motor vehicle accident-related examinations for discovery. Nor are reliable data available as to the time spent on pre-trials in motor vehicle accident litigation. Data are available in some areas of the province as to the time spent on pre-trials; however, they do not disclose how much of that pre-trial time related to motor vehicle accident cases.

As indicated, a case is not generally considered to be eligible for trial until it has been pre-tried.

Therefore, the number of cases set down for trial at any given time is not particularly illuminating. Cases set down for trial are often far from ready for trial. The present system is being abused; in particular, cases are often set down for trial before examinations for discovery have been held or completed. The situation is further complicated by a practice direction requiring a pre-trial to be held within one year of the action having been set down for trial. Because of that practice direction pre-trials are at times scheduled before discoveries were completed.

I think it is important for administration purposes that there be a better identification of cases which are ready for trial. The most significant identifying factor is the completion of a pre-trial. I therefore recommend that the Rules of Civil Procedure be amended so as to create two lists:

(1) a list of cases set down for pre-trial; and

(2) a list of cases ready to be tried.

Actions should not be set down for pre-trial until counsel setting the action down has specifically certified that he has completed discoveries and is ready for trial.

The cases-to-be-tried list should consist of pre-tried cases which have been certified as ready for trial by the pre-trial judge. The onus should be on counsel to arrange the pre-trial. In this way, the trial list will disclose cases that are in fact ready for trial. The Notice of Readiness for Trial system has not accomplished this. For example, in June 1987 there were 1,642 cases on

the Supreme Court non-jury list; only 305 had been pre-tried. It follows that the remaining 1,337 cases on the trial list were not ready for trial.

I further recommend that the Attorney General's data collection procedures be expanded so as to capture data relating to the number of, and time consumed by, pre-trials as related to the same classification of cases (including motor vehicle cases) on which data are now recorded.

Figures 9.1 and 9.2 show motor vehicle accident proceedings commenced and actions set down for jury and non-jury trial for the four-year period between 1982 and 1985 in the Supreme and District Court respectively. As can be seen in Figure 9.1, the number of actions commenced in the Supreme Court declined during the period 1982 to 1985, although there was a small increase in 1985 over 1984. The number of Supreme Court actions set down for both jury and non-jury trial remained more or less stable in that period. The same stability shows for actions set down for trial in the District Court (Figure 9.2).

Figure 9.1

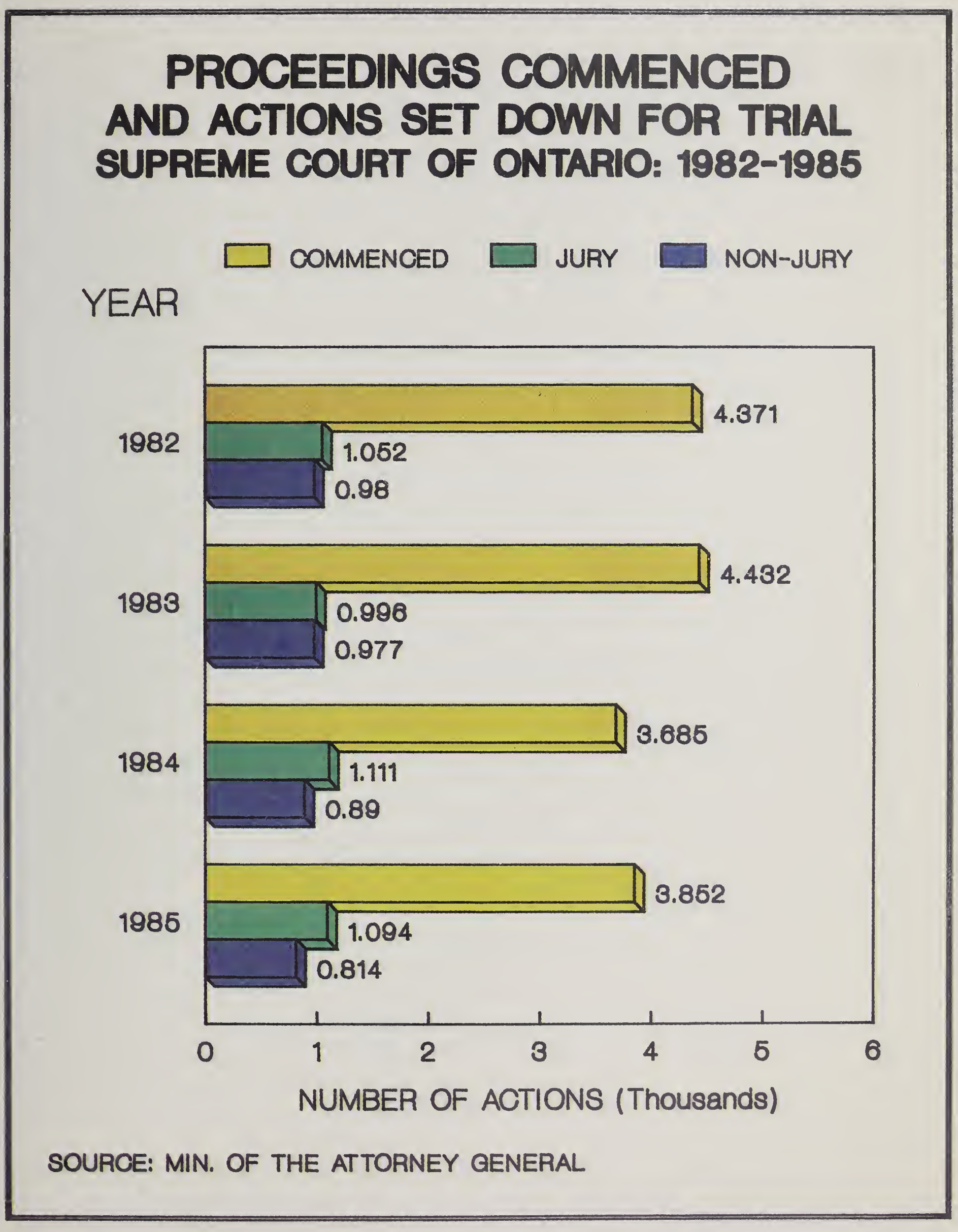
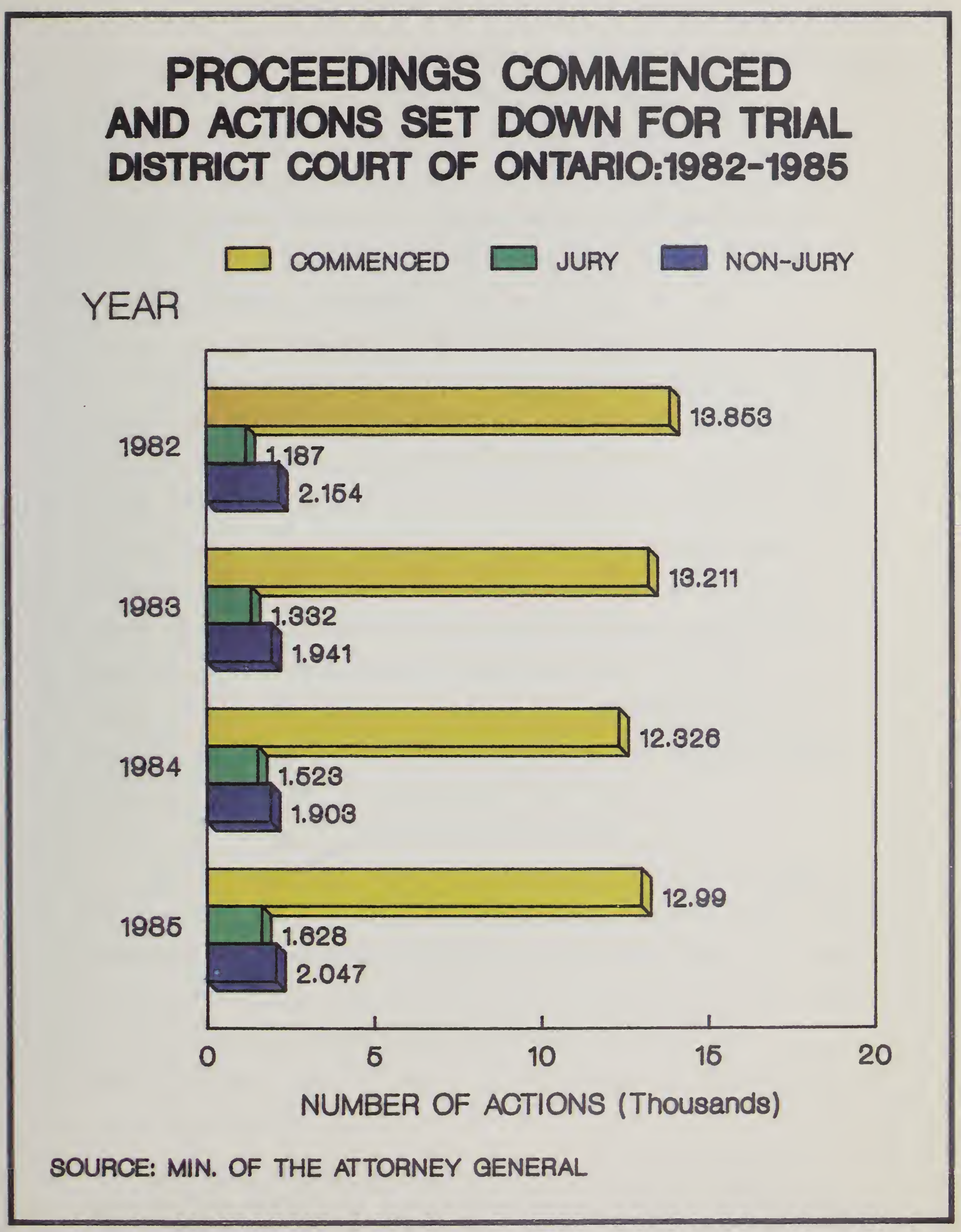

PROCEEDINGS COMMENCED
AND ACTIONS SET DOWN FOR TRIAL
SUPREME COURT OF ONTARIO: 1982-1985
COMMENCED
JURY
NON-JURY
YEAR
1982
4.371
1.052
0.98
1983
4.432
0.996
0.977
1984
3.685
1.111
0.89
1985
3.852
1.094
0.814
0
1
2
3
4
5
6
NUMBER OF ACTIONS (Thousands)
SOURCE: MIN. OF THE ATTORNEY GENERAL

Figure 9.2


PROCEEDINGS COMMENCED
AND ACTIONS SET DOWN FOR TRIAL
DISTRICT COURT OF ONTARIO:1982-1985
COMMENCED
JURY
NON-JURY
YEAR
1982
13.853
1.187
2.154
1983
13.211
1.332
1.941
1984
12.326
1.523
1.903
1985
12.99
1.628
2.047
0
5
10
15
20
NUMBER OF ACTIONS (Thousands)
SOURCE: MIN. OF THE ATTORNEY GENERAL

Figures 9.3 and 9.4 show the percentage breakdown of motor vehicle actions on the Supreme Court trial lists in 1979-1980 (Figure 9.3) and 1985-1986 (Figure 9.4). Figures 9.5 and 9.6 show the same breakdown in the same years for District Court motor vehicle cases. All of these figures reflect all motor vehicle actions on the trial lists in the Supreme and District Courts including actions pending at close.[9]

There have been an increasing number of motor vehicle actions in which jury notices have been served (mostly by the defence). This requires some comment. In 1979-1980, 39.8% of motor vehicle actions set down for trial in the Supreme Court were jury actions; 60.2% were non-jury actions. By 1985-1986, the proportions were reversed; close to 60% of Supreme Court motor vehicle actions set down for trial were jury actions. In the Judicial District of York (Toronto) 74.4% of the motor vehicle actions set down for trial in 1985-1986 in Supreme Court were jury actions.

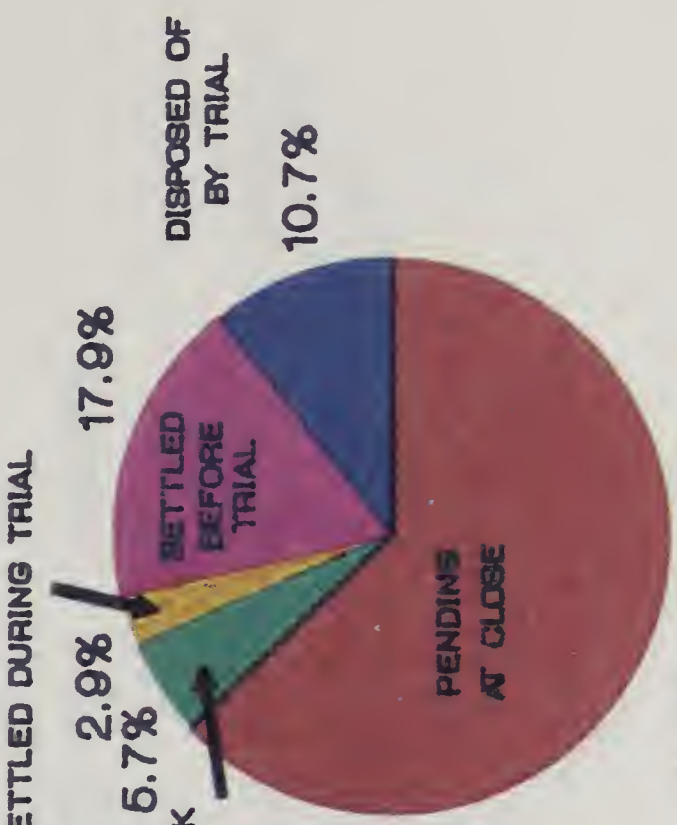
In the District Court in 1979-1980, 27.4% of motor vehicle actions set down for trial were jury actions. By 1985-1986, 47% of motor vehicle actions set down for trial were jury actions. In the Judicial District of York, 60% of the District Court cases set down for trial in 1985-1986 were jury trials. If the Judicial District of

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[9]The Ministry of the Attorney General's court records include the number of cases pending at close. These are cases which are not reached for trial or perhaps not ready for trial; in any event cases pending at close represent cases not actually dealt with by the system.

Figure 9.3

DISPOSITION OF MOTOR VEHICLE ACTIONS ON LIST FOR TRIAL SUPREME COURT OF ONTARIO: 1979 - 1980



SOURCE: MIN. OF THE ATTORNEY GENERAL

Figure 9.4

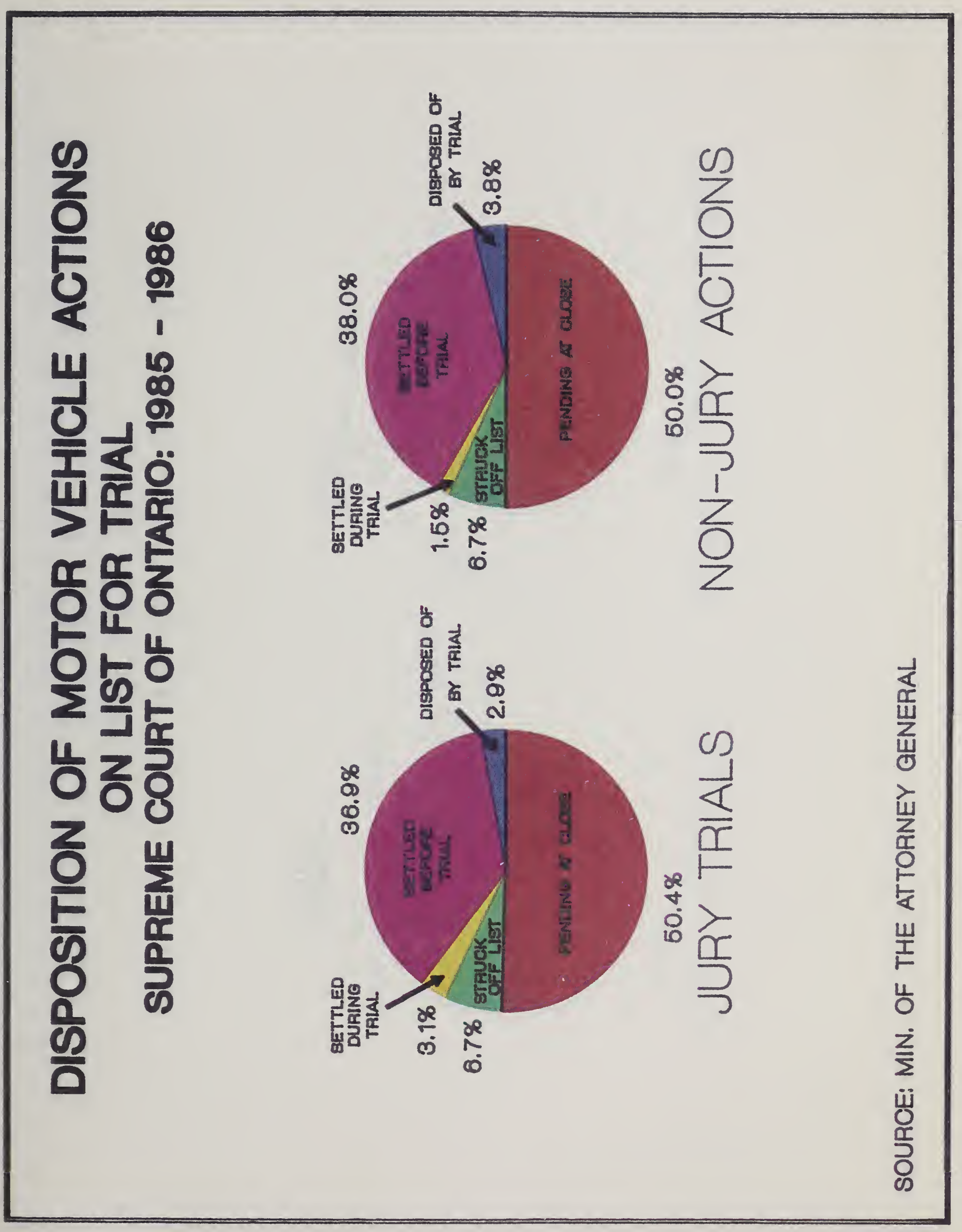

DISPOSITION OF MOTOR VEHICLE ACTIONS
ON LIST FOR TRIAL
SUPREME COURT OF ONTARIO: 1985 - 1986
NON-JURY ACTIONS
SETTLED DURING TRIAL
1.5%
SETTLED BEFORE TRIAL
38.0%
STRUCK OFF LIST
6.7%
DISPOSED OF BY TRIAL
3.8%
PENDING AT CLOSE
50.0%
JURY TRIALS
SETTLED DURING TRIAL
3.1%
SETTLED BEFORE TRIAL
36.9%
STRUCK OFF LIST
6.7%
DISPOSED OF BY TRIAL
2.9%
PENDING AT CLOSE
50.4%
SOURCE: MIN. OF THE ATTORNEY GENERAL

Figure 9.5

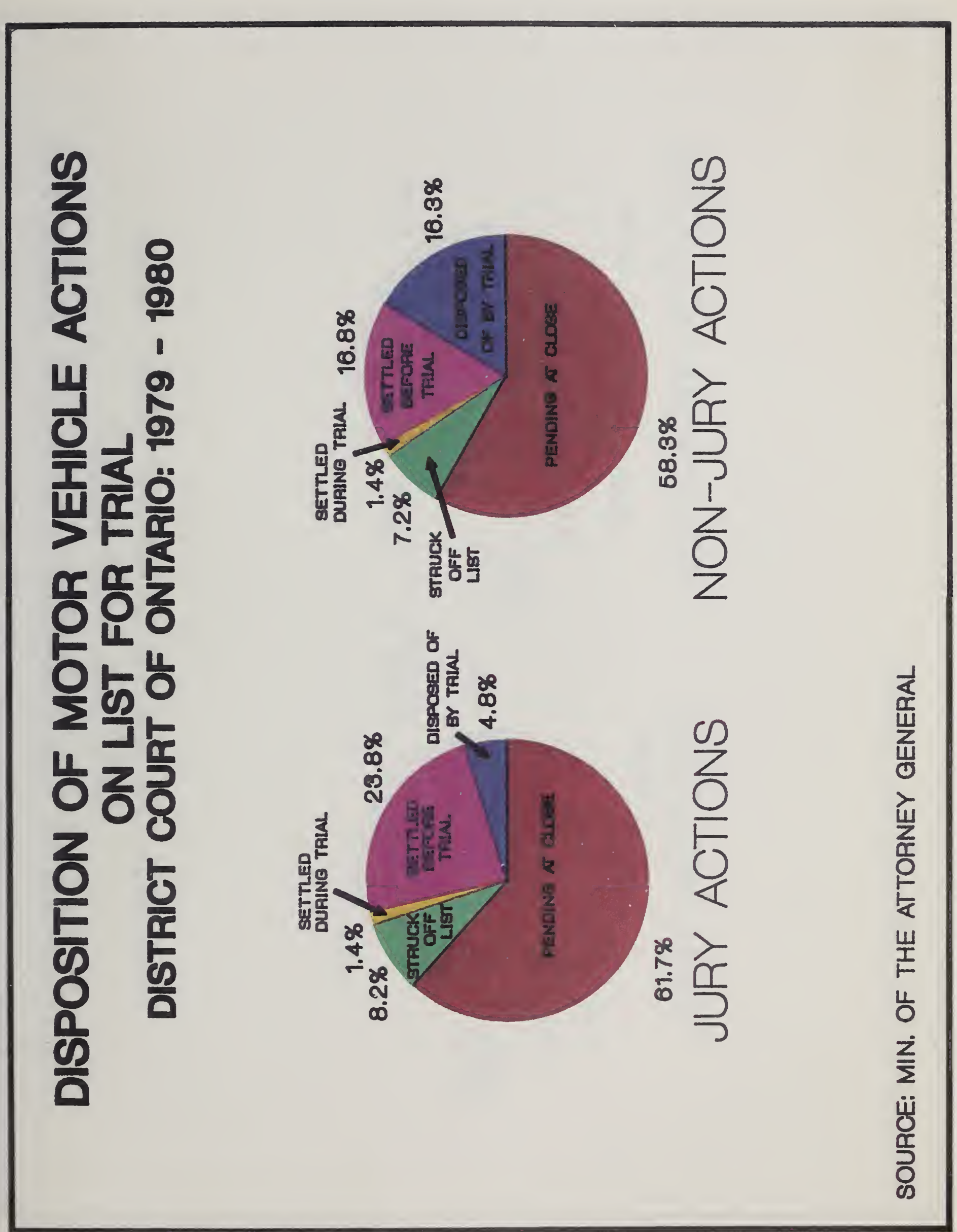
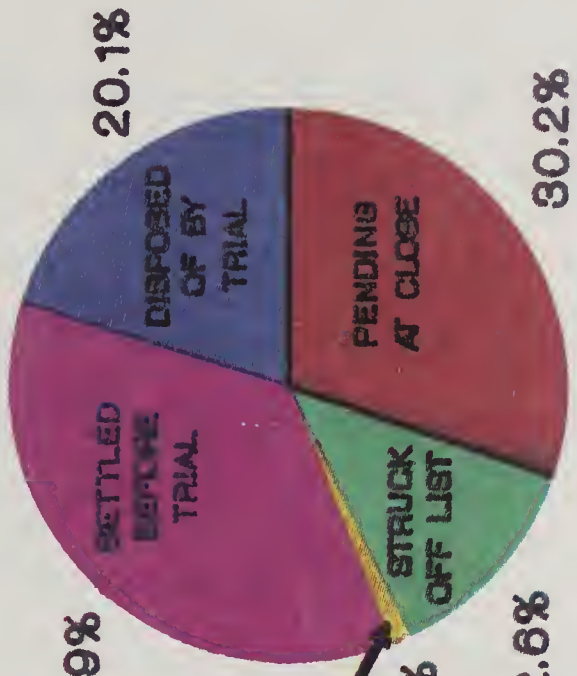
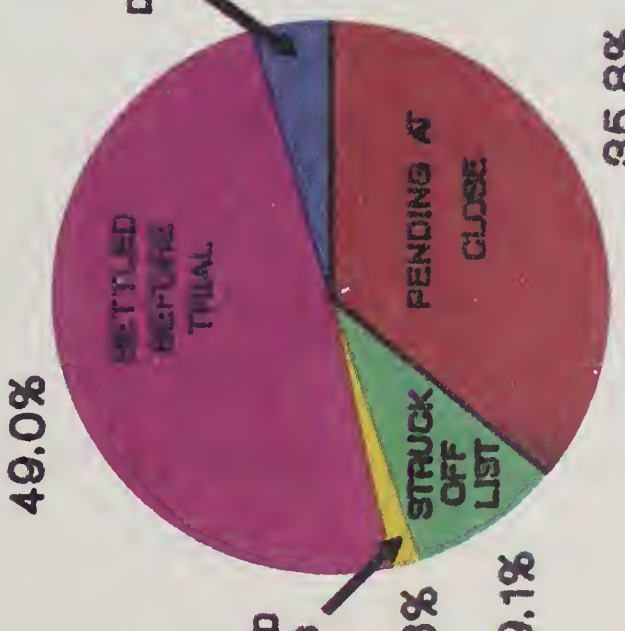

DISPOSITION OF MOTOR VEHICLE ACTIONS
ON LIST FOR TRIAL
DISTRICT COURT OF ONTARIO: 1979 - 1980
SETTLED DURING TRIAL
1.4%
SETTLED BEFORE TRIAL
18.8%
DISPOSED OF BY TRIAL
16.3%
STRUCK OFF LIST
7.2%
PENDING AT CLOSE
58.3%
NON-JURY ACTIONS
SETTLED DURING TRIAL
1.4%
SETTLED BEFORE TRIAL
23.8%
DISPOSED OF BY TRIAL
4.8%
STRUCK OFF LIST
8.2%
PENDING AT CLOSE
61.7%
JURY ACTIONS
SOURCE: MIN. OF THE ATTORNEY GENERAL

Figure 9.6

DISPOSITION OF MOTOR VEHICLE ACTIONS ON LIST FOR TRIAL DISTRICT COURT OF ONTARIO: 1985 - 1986



NON-JURY ACTIONS



JURY ACTIONS

SOURCE: MIN. OF THE ATTORNEY GENERAL

York data are excluded, the District Court jury/non-jury experience in 1985-1986 indicates that 33.5% of District Court motor vehicle actions were set down as jury cases. Obviously, juries are resorted to more frequently by Toronto counsel in Toronto cases.

These conclusions seem to me to be evident from the available evidence:

(1) There has been a significant increase in the number of jury actions in both Supreme and District Courts.

(2) The increase in the delivery of a jury notice is most significant in Toronto in both courts. This is particularly so in Supreme Court motor vehicle cases.

(3) Most jury notices are served by defendants.[10]

(4) The percentage of Supreme Court cases which settled before trial was about the same for jury and non-jury cases in 1985-1986 (36.9% jury and 38.0% non-jury.) This is contrary to the popular wisdom that jury trials settled more often than non-jury trials.

(5) There has been a significant reduction in the percentage of Supreme Court motor vehicle non-jury actions tried. In the 1979-1980 period, 10.7% of non-jury motor vehicle actions were tried; in 1985-86 3.8% were tried. This decline is likely attributable to the increasing impact of the pre-trial in promoting settlement.

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[10] This is based on my experience and has been confirmed by registrars and trial coordinators.

(6) In the District Court in both 1979-1980 and 1985-1986, there was a substantial difference in the trial and settlement rates of jury and non-jury motor vehicle cases. In both timeframes, a greater percentage of non-jury actions went to trial. In 1979-1980, 4.8% of District Court motor vehicle jury actions were tried, while 16.3% of District Court motor vehicle non-jury actions were tried. In 1985-1986, 4.5% of jury actions were tried (almost the same as the 1979-1980 percentage), but 20.1% of District Court non-jury motor vehicle actions were tried. The rate of jury cases settled before trial is demonstrably higher in the District Court for jury than non-jury cases.

(7) In both the Supreme and especially the District Court, significant progress seems to have been made in the reduction of the number of cases pending at close between 1979-1980 and 1985-1986 (see Figures 9.3 to 9.6).

I have received some submissions recommending the abolition of civil jury trials. I think, on balance, the civil jury system ought to be preserved, although I recommend that the Ministry of the Attorney General examine the cost of civil jury actions and that the Ministry consider increasing the fee paid for setting an action down for jury trial. As earlier stated, in motor vehicle litigation, insurers caused most jury notices to be served. Almost universally, counsel for insurers suggest there are two reasons for this. First, the uncertainty created by the presence of a jury works to the advantage of the defendant (the defendant's insurer).

Most plaintiffs cannot afford to gamble; the insurer can afford to take the risk presented by the uncertainty of a jury verdict. Second, it is thought that juries, unlike trial judges, will reject most or all of the evidence of a witness if the jury finds reason to reject any material part of it. This propensity is more pronounced in those cases where there is some evidentiary foundation for the rejection of the plaintiff's evidence, or even the evidence of an expert witness. This, of course, works both ways. A jury may be more inclined than a trial judge to reject defence evidence; however, in practical terms, it is usually the plaintiff's evidence which is crucial to establishing damages and liability.

If the fees for setting an action down for a jury trial are increased, impecunious plaintiffs will not be placed in a disadvantageous position. If those plaintiffs are funded by legal aid, disbursements will be paid in the ordinary course of events. If an impecunious plaintiff is not assisted by legal aid, plaintiff's counsel will temporarily absorb the jury notice fee. If any reasonable fee is imposed it will, in the final analysis, be significantly less than the cost of a routinely acquired medical/legal report. That fee, if in the range of $50 to $100, should not pose an undue burden on litigants.

I do not mean to suggest that trial by jury should be viewed as a luxury. There are, however, significant costs which I have not examined which result from the service of a jury notice in a civil action. A jury panel has to be assembled; the entire panel is paid, albeit modestly. All jurors are paid for jury duty once selected as jurors. There are, in addition, external costs (time off work or

time away from home, babysitting expenses, etc.) which I have not calculated.

Although it is useful to have data as to the percentage of cases tried, struck off the list, settled before trial, settled during trial and pending at close, those percentages do not disclose what percentage of cases actually dealt with by the system was tried. Cases pending at close and cases struck off the list represent cases not disposed of. As previously indicated, many of the cases pending at close, and for that matter most cases struck off the list, are cases which were not ready for trial.

Table 9.2 below sets out the breakdown of motor vehicle cases disposed of in the Supreme Court in 1979-1980 and in 1985-1986 with regard to trials, cases settled before trial and cases settled during trial. Table 9.2 provides a breakdown for all of Ontario, the Judicial District of York and the remainder of Ontario for the 1985-1986 period. Table 9.3 sets out the same information for the District Court in the same two timeframes. As indicated Tables 9.2 and 9.3 deal only with the cases which were dealt with by the system in the relevant time periods. The percentage calculations ignore cases pending at close and struck off the trial list. As can be seen from Figures 9.3 to 9.6 the percentage of motor vehicle actions pending at close was substantial in both timeframes assessed.

Table 9.2 shows a significant reduction in the percentage of cases tried in the Supreme Court in 1985-1986 compared to the 1979-1980 period. Of the Supreme Court non-jury motor vehicle cases disposed of in 1979-

TABLE 9.2

SUPREME COURT

CASES DISPOSED OF IN 1979-1980[11]

ONTARIO

JURY		NON-JURY	
Trials:	12.1%	Trials:	33.8%
Settled pre.:	79.3%	Settled pre.:	56.9%
Settled at:	8.4%	Settled at:	9.3%

CASES DISPOSED OF IN 1985-1986

ONTARIO

JURY		NON-JURY	
Trials:	6.7%	Trials:	8.7%
Settled pre.:	86.1%	Settled pre.:	87.7%
Settled at:	7.2%	Settled at:	3.6%

YORK

JURY		NON-JURY	
Trials:	4.3%	Trials:	8.1%
Settled pre.:	92.0%	Settled pre.:	92.9%
Settled at:	3.7%	Settled at:	0.0%[12]

REMAINDER

JURY		NON-JURY	
Trials:	9.6%	Trials:	8.9%
Settled pre.:	78.9%	Settled pre.:	86.3%
Settled at:	11.5%	Settled at.:	4.8%

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[11] Cases disposed of do not include cases struck off the trial list or cases not reached (pending at close).

[12] This figure must be wrong. Perhaps the 91.9% settled before trial figure includes cases settled after the commencement of trial.

1980, 33.8% were disposed of by trial; of Supreme Court non-jury motor vehicle cases disposed of in 1985-1986, 8.7% were disposed of by trial. The explanation for this change lies in the fact that there was a significant increase in the percentage of cases settled before trial.

Table 9.2 also shows a similar, if less pronounced, trend for Supreme Court jury trials in a comparison of 1978-1979 and 1985-1986 periods. In 1979-1980, 12.1% of the Supreme Court jury actions disposed of were tried; in 1985-1986, 6.7% were tried.

Table 9.3 shows a significantly lower trial rate for District Court jury and non-jury motor vehicle accident cases in 1985-1986 than in 1979-1980. In 1985-1986 in the District Court, 35.1% of the non-jury cases disposed of, were disposed of by trial while 8.2% of the jury cases disposed of were disposed of by trial. The District Court rate for motor vehicle jury cases settled before trial is 88.9%, and 62.8% for non-jury cases. One might speculate that if there were no motor vehicle jury trials, the system would be exposed to shorter but more trials.

It is apparent that in the District Court between the 1978-1979 period and the 1985-1986 period there was a significant increase in the number of non-jury cases settled before trial. It is this increase which has resulted in a lower percentage of cases being tried. In my opinion, it is likely that this change for the better is attributable to the expanding impact of the pre-trial process in the 1978-1986 period.

I have sought the advice of judges, lawyers, registrars and trial coordinators in attempting to

TABLE 9.3

SUPREME COURT

CASES DISPOSED OF IN 1979-1980

ONTARIO

JURY		NON-JURY	
Trials:	16.0%	Trials:	47.1%
Settled pre.:	79.3%	Settled pre.:	48.8%
Settled at:	4.7%	Settled at:	4.1%

CASES DISPOSED OF IN 1985-1986

ONTARIO

JURY		NON-JURY	
Trials:	8.2%	Trials:	35.1%
Settled pre.:	88.9%	Settled pre.:	62.8%
Settled at:	2.3%	Settled at:	2.1%

YORK

JURY		NON-JURY	
Trials:	6.9%	Trials:	29.7%
Settled pre.:	92.0%	Settled pre.:	70.1%
Settled at:	1.1%	Settled at:	0.2%

REMAINDER

JURY		NON-JURY	
Trials:	10.2%	Trials:	38.1%
Settled pre.:	84.1%	Settled pre.:	58.8%
Settled at:	5.7%	Settled at.:	3.1%

determine if the presence of motor vehicle action unduly burdens the courts. Their advice and the data previously referred to lead me to the conclusion that the courts are not overburdened with motor vehicle cases. There are a great number of motor vehicle cases on trial lists. There

is no doubt that motor vehicle accident cases dominate civil jury lists. As has been previously stated, a great majority of motor vehicle cases set down for trial are resolved by settlement before trial. Human nature being what it is, many of those cases, although settled, are not settled until the last moment. This causes disruption to jurors and inconvenience to cases, both jury and non-jury, which may follow. At the District Court level, this problem will be reduced by the removal of cases under $10,000 from the District Court jury system. Obviously, the Provincial Court will have to be significantly expanded.[13]

I have reviewed data from registrars and trial coordinators in Toronto and in selected communities outside Toronto[14] in an attempt to determine the extent to which trial time is consumed by motor vehicle accident litigation. It is one thing to consider the percentage of motor vehicle accident cases that go to trial; it is another thing to consider how much of the system's time is consumed by those cases. No hard conclusions can be reached on the basis of the data I have received. Some motor vehicle cases are lengthy, lasting a number of weeks; other motor vehicle cases consume less than an hour of court time from beginning to end. It would appear that, on average, motor vehicle accidents take no more, or no less, time to try than other actions.

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[13] I assume there will be no juries in the Provincial Court.

[14] I am grateful to the Toronto Trial Office and to registrars or trial coordinators in Windsor, Welland, London, Kitchener and Sudbury.

I conclude where I began. Motor vehicle cases have an obvious presence on trial lists; however, as a result of settlements, motor vehicle litigation does not consume an inordinate amount of court trial time. While there may be other valid arguments to support the demolition of the tort system, the undue clogging of the courts is not among them.

More information as to resources committed before trial to motor vehicle litigation, and for that matter to all litigated claims, is required. I have in mind, judge time committed to pre-trials in motor vehicle and other cases. Data in this important area are not available.

CHAPTER 10

COMPENSATION ISSUES

A. INTRODUCTION

I received a number of submissions which recommended changes to certain of the existing legal principles governing compensation for victims of motor vehicle accidents. Some of the submissions dealt with changes to liability rules, others with changes to the rules relating to the assessment of damages. The proposals addressed six main issues -- gross-up, family law claims for loss of guidance, care and companionship, the collateral source rule, prejudgment interest, joint and several liability and the discount rate. All of these issues have application beyond motor vehicle accident compensation. They raise not only matters of principle, but also questions of cost. Many who urge "tort reform" view it as a means to preserve the existing system for compensation and at the same time, reduce its cost.

These issues have also been very recently dealt with by the Ontario Law Reform Commission (O.L.R.C.). In November 1985, the O.L.R.C. appointed Professor Stephen Waddams of the Faculty of Law, University of Toronto as Director of a Project on Compensation for Personal Injuries and Death (the O.L.R.C. Project). The O.L.R.C. Project was both broader and narrower than my mandate. It was broader in the sense that it dealt with compensation for personal injuries beyond those caused by motor vehicle accidents; it was narrower in that it was

premised on the continued existence of the tort system.[1] The O.L.R.C. cooperated fully with the Inquiry by making available all of its research papers, together with Professor Waddams' own review. The O.L.R.C. Report was delivered to the Attorney General in November 1987. A copy of the O.L.R.C. Report was made available to me. I have reviewed the O.L.R.C. recommendations, and in what follows I have commented on them to the extent that I have felt it appropriate.[2]

B. FAMILY LAW REFORM ACT AND FAMILY LAW ACT CLAIMS

At common law, surviving family members had no cause of action for the death of one of their number.[3] The unfairness of this common law rule became more apparent as industrialization and the number of fatal accidents increased.[4] This led to statutory reform in England with the passage of Lord Campbell's Act in 1846. This statute, which became a model for wrongful death statutes elsewhere, gave certain surviving relatives a right of action to recover the damages sustained by them as a result of the death of a family member, provided that the deceased would have had a cause of action for the

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[1] The issue of joint and several liability was not considered in the O.L.R.C. Project. It is, however, being considered by the O.L.R.C. in its Contribution Among Wrongdoers Project.

[2] I am grateful to the Chairman of the O.L.R.C. and to the Waddams Committee for their assistance.

[3] Baker v. Bolton (1808), 170 E.R. 1033; Admiralty Commissioners v. S.S. "Amerika", [1917] A.C. 38.

[4] Mason v. Peters (1982), 39 O.R. (2d) 27 (C.A.).

wrongfully inflicted injury. In 1847, Ontario passed the Fatal Accidents Act, the equivalent of Lord Campbell's Act.[5]

The courts consistently held that damages under the Fatal Accidents Act could be given for pecuniary loss only.[6] Damages, in the nature of a compassionate allowance or for grief or mental anguish or loss of companionship, were not recoverable. In the case of the death of young children, the rule limiting damages to pecuniary loss was particularly harsh. The most important loss was "companionship" and it was not compensable as it was essentially non-pecuniary in character.[7] The strict requirement of pecuniary loss was modified somewhat in Ontario in cases like Vana v. Tosta, where the loss of care and guidance suffered by a child as a result of a parent's death were held to be compensable.[8] In non-fatal cases, apart from the outmoded claim for loss of consortium, family members could not recover at common law for loss of care, guidance and companionship no matter how serious the injury to the victim.

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[5] 10 & 11 Vict. L. Chap. 6. The statutory remedy was afforded to the husband, wife, parent (including grandparent) and child (including grandchild) of the deceased.

[6] Mason v. Peters, at p. 31.

[7] Mason v. Peters, at pp. 32-33.

[8] Vana v. Tosta, [1968] S.C.R. 71; St. Lawrence and Ottawa Railway Co. v. Lett (1885), 11 S.C.R. 422. They were held capable of evaluation on a monetary basis and therefore compensable as pecuniary loss.

In 1978 the Family Law Reform Act (F.L.R.A.) was enacted.[9] It abolished the Fatal Accidents Act.[10] It put the law of Ontario with respect to fatal and non-fatal injuries on the same basis. It firmly established the entitlement to compensation for the loss of guidance, care and companionship in both fatal and non-fatal cases. The F.L.R.A. enlarged the circle of claimants to include brothers and sisters of the person injured or killed. The F.L.R.A. has now been superseded by the Family Law Act, 1986.[11] The new statute contains no changes in eligible claimants or in guidance, care and companionship compensation.

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[9]S.O. 1978, c. 2. Section 60 provided in part as follows:

60. (1) Where a person is injured or killed by the fault or neglect of another under circumstances where the person is entitled to recover damages, or would have been entitled if not killed, the spouse, as defined in Part II, children, grandchildren, parents, grandparents, brothers and sisters of the person are entitled to recover their pecuniary loss resulting from the injury or death from the person from whom the person injured or killed is entitled to recover or would have been entitled if not killed, and to maintain an action for the purpose in a court of competent jurisdiction.

(2) The damages recoverable in a claim under subsection (1) may include,...

(d) an amount to compensate for the loss of guidance, care and companionship that the claimant might reasonably have expected to receive from the injured person if the injury had not occurred.

[10]Family Law Reform Act (F.L.R.A.), S.O. 1978, c. 2, s. 79.

[11]S.O. 1986, c. 4, s. 61(2)(e).

Discussion of tort reform in this area has focused on subsection 61(2)(e), the subsection that allows compensation for the loss of guidance, care and companionship. In Mason v. Peters, the Ontario Court of Appeal held that "guidance, care and companionship including as they do imponderable elements of loss are essentially non-pecuniary in character".[12]

Insurers and others have made submissions complaining that there have been too many claimants seeking recovery under subsection 61(2)(e); that many claimants have successfully advanced claims of a minor or trivial nature; and that in the aggregate the awards have been costly. Three different proposals have been put forward to limit recoveries for loss of guidance, care and companionship. One proposal is to restrict recovery only to those losses of guidance, care and companionship that are either serious or permanent.[13] A second proposal involves restricting the eligible claimants to household members. A third proposal is to provide for conventional awards.[14]

Surprisingly, insurance company complaints about awards for loss of guidance, care and companionship have

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[12]At p. 38. The court recognized that pecuniary loss concepts in cases involving the wrongful death of young children had provided awards wholly out of proportion to the true loss sustained by a child's death.

[13]This would add a new question to be litigated and may have the effect of inflating claims to bring them within the criteria of serious or permanent.

[14]This approach has been adopted in England and Alberta. See Nielsen v. Kaufmann, 54 O.R. (2d) 189.

been made without any empirical data to indicate the aggregate cost of these awards. Insurers generally do not record what has been paid for family law claims.[15]

Accordingly, the breakdown of the cost of components of motor vehicle claims became an important part of the Inquiry Claims Survey. The Claims Survey revealed that F.L.R.A. and F.L.A. claims payments accounted for 5.4% of all bodily injury liability claims paid.[16] The Claims Survey also showed that about 30% of F.L.R.A. and F.L.A. claims payments were made in non-fatal accident cases. It follows that 1.6% of bodily injury liability claims dollars goes to family law claims in non-fatal cases. The main focus of the complaints about compensation for loss of guidance, care and companionship are in non-fatal cases. The small amount involved detracts from the legitimacy of the complaint. In fatal accident cases it seems reasonable to conclude that pecuniary loss compensation exceeds compensation paid for guidance, care and companionship, at least in cases where the deceased

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[15]The I.B.C. in its 1987 claims survey did provide figures on family law claims, Appendix XVII.

[16]The full breakdown of bodily injury liability claim payments was as follows:

Past employment income loss	13.3%
Past out-of-pocket expense	2.5%
Future employment income loss	10.1%
Future care expense	1.4%
Non-pecuniary loss	45.7%
Family law claims	5.4%
Gross-up	0.4%
Party-and-party costs	11.0%
Prejudgment interest	10.2%
	100.0%

was an income earner. Because of the relatively few fatal accident claims in Ontario, it seems to me that the guidance, care and companionship part of settlements or judgments in those claims does not account for a very significant amount of the claims dollars.

Approximately 86% of all F.L.A. payments were made to the claimant's spouse, children or parents; 11% was paid to brothers and sisters and 3% to grandparents. On average, 8.7% of the claimants had family law claims. In approximately three-quarters of these claims, the payments were shared by no more than two relatives.

The statistical evidence does not suggest excessive cost associated with F.L.R.A. or F.L.A. claims. Nor does it suggest that the assertion of trivial claims by numerous relatives is widespread. Even the survey data, dealing as they do with claims files closed during 1986, may overstate expected future loss costs attributable to the guidance, care and companionship part of the F.L.R.A. claims payments. The claims survey does not take account of the impact of two recent developments, one procedural, the other substantive, which should reduce both the number of F.L.A. claimants and the amount of awards for loss of guidance, care and companionship.

The procedural change is that the prohibition in the F.L.R.A. against bringing more than one action in respect of the same occurrence was eliminated.[17] In an action under section 60 of the former statute the plaintiff was

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[17] Subsection 60(4).

required in his statement of claim to name and join the claim of any other person who was entitled to maintain an action. The plaintiff was further required to file an affidavit with the statement of claim stating that the persons named were the only persons entitled to claim damages under section 60.[18] These former procedural provisions had the practical effect of encouraging claims of a relatively minor nature. Solicitors were obligated to make inquiries of relatives to ascertain whether they wished to assert a claim. As a matter of prudence, solicitors named these relatives and sought confirming instructions later.[19]

Under the new F.L.A., any relative with a claim must bring his or her own action. The likely effect is that trivial claims are not made. The relatively large transaction costs associated with these claims are significantly reduced.

The substantive change in claims for loss of guidance, care and companionship comes from two decisions of the Ontario Court of Appeal which have served to moderate these claims. In Nielsen v. Kaufmann,[20] the Court, while rejecting the notion of "conventional" awards for loss of

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[18] Section 62.

[19] See Donaldson v. Piron, 41 C.P.C. 92.

[20] 54 O.R. (2d) 189.

guidance, care and companionship,[21] stressed that there had to be an actual loss. The Court stated:

> Although essentially non-pecuniary in character, there must be an actual loss of care, companionship and guidance. A brother of a deceased, for example, who lives in Vancouver and who has not seen the deceased, who lives in Toronto, for 20 years, although they exchange Christmas cards and a telephone call a year, would not, in our view, be entitled to any compensation. Undoubtedly, there would be grief and sorrow and a sense of loss but, under the circumstances recited, there would be no loss compensable under the section. This is not to minimize the importance of the section but, as we have stated, the mere fact of the relationship does not, of itself, establish the right to some compensation.

In Reidy v. McLeod,[22] the trial judge awarded damages of $111,500 to eight members of the family of one deceased and $93,000 to six members of the family of the other deceased. The Court of Appeal reduced each of the aggregate awards to $40,000. In the one instance, the claims of five relatives were dismissed and, in the other

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[21] The Court said:

> In time, there may be awards for the loss of care, guidance and companionship in the 'average' family which will come to be recognized as 'conventional'. It is difficult now to see how such a family can be discovered or described.

Compare Gervais v. Richard, 48 O.R. (2d) 191 where Krever, J. said:

> In my view awards for loss of guidance, care and companionship ... must essentially become conventional awards.

[22] 54 O.R. (2d) 661, reversing 47 O.R. (2d) 313.

instance, the claims of four relatives were dismissed. In the reasons of the Court is the following passage:

> In the present case, there can be no question of the enormous grief and mental anguish suffered by the parents and brothers and sisters of the deceased boys. But losses of this kind are non-compensable. Details of the quality of family life and the relationship of family members do not in themselves form a basis of recovery under s. 60; they are significant only in so far as they furnish an evidentiary foundation for assessing compensation for the loss of care, guidance and companionship that will likely be suffered by reason of the death. This assessment must be made in as objective and unemotional a manner as possible in these sad cases.[23]

The social policy underlying section 61 is a sensible one. As Mr. Justice Robins said in Mason v. Peters, section 61 of the F.L.A.:

> evidences the Legislature's intention to accord greater recognition to the interest in family relations and provide greater protection against wrongful disturbance or destruction of that advantageous relationship.[24]

In light of the empirical evidence and the recent changes in the law, both legislative and judicial, I do not think a case has been made to amend subsection 61(2)(e) of the F.L.A.

Before leaving the subject, I wish to comment on the recommendations in the O.L.R.C. Report. The Commissioners, with one dissenting voice, are of the view that all recovery for loss consequent upon an injury be

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[23] At p. 662.

[24] Mason v. Peters, at p. 37.

channelled through the injured person or his estate.[25] The O.L.R.C. Report recommends abolishing third party claims for guidance, care and companionship and replacing these claims, in both fatal and non-fatal cases, with a first party claim for loss of capacity to provide guidance and care (but not companionship). The majority of the Commissioners concluded that the claim should be viewed from the perspective of the injured person's capacity to provide guidance and care. The Report also recommends restricting the class of claimants to spouses, dependant children and dependant parents. One Commissioner in dissenting from these recommendations proposed that the current provisions remain intact.

The current statutory scheme is based on the principle that certain family members experience a real loss, not always pecuniary in nature, upon the injury or death of a relative for which an award of damages is justified. The recommendations of the O.L.R.C. are premised on the notion that compensation for care and guidance should be measured by the extent to which the injured person's (or deceased's) capacity to provide care and guidance has been reduced (or eliminated). I would go further than the dissenting Commissioner who concluded that neither principle has any more validity than the other. It seems to me the principles underlying the awarding of compensation for guidance, care and companionship as set

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[25] See Ontario Law Reform Commission, Report on Compensation for Personal Injuries and Death, Vol. I (Toronto, Ontario: Ministry of the Attorney General, 1987), pp. 65-82. [Henceforth: O.L.R.C., Report, Vol. I (1987)] and Dissent by Margaret A. Ross, pp. 160-171.

forth in the F.L.A. are on balance to be preferred to those underlying the O.L.R.C. majority recommendation.

Claims survey data lead to the conclusion that changes cannot be justified on a cost basis. Nor do I think that the concern about nuisance claims or the possibility of multiple actions justifies abolishing or substantially changing section 61, particularly having regard to the procedural change under the new Act and the recent case law. Further, although the O.L.R.C. recommendation would mean only one action, the proposed assessment, notice, apportionment and distribution procedures are far more cumbersome than the existing system which permits separate claims, but usually involves only one action.

Finally, the proposal to eliminate claims for loss of "companionship" is, in my view, not warranted. There is now an established jurisprudence dealing with the phrase "guidance, care and companionship" and I am not persuaded that there is anything to be gained by removing one component of that phrase. A principal reason for the Commission's recommendation was to reduce or eliminate entirely the need to investigate the nature of the relationship between the injured or deceased and the person to whom care and guidance was provided. As I view it, even under the O.L.R.C.'s proposals, there will be a need for that inquiry, however unfortunate or distasteful it may be in some cases.

C. PREJUDGMENT INTEREST

In Ontario, prior to 1977, there was no statutory provision for prejudgment interest.[26] Absent such a provision, defendants had a disincentive to settle litigation and a corresponding incentive to delay the trial of an action as long as possible.[27]

The situation was rectified by amendments to the Judicature Act effective November 25, 1977.[28] The current provision for prejudgment interest is found in section 138 of the Courts of Justice Act[29] which states as follows:

> **Prejudgment interest**
> 138(1) A person who is entitled to an order for the payment of money is entitled to claim and have included in the order an award of interest thereon at the prejudgment rate, calculated,
> (a) where the order is made on a liquidated claim, from the date the cause of action arose to the date of the order; or
> (b) where the order is made on an unliquidated claim, from the date the person entitled gave notice in writing of his claim to the person liable therefor to the date of the order.

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[26] At common law, a defendant was not required to pay interest on damages that had accrued to the time of trial. See Waddams, The Law of Damages (1983), pp. 495-6.

[27] Even post-judgment interest was only payable at the 5% statutory rate provided for in the Interest Act, R.S.C. 1970, c. I-18. This gave defendant insurers an incentive to appeal an award because they could obtain a rate of return more than 5% on the large sums of money which would inevitably be paid.

[28] S.O. 1977, c. 51.

[29] S.O. 1984, c. 11.

Special damages

(2) Where the order includes an amount for special damages, the interest calculated under subsection (1) shall be calculated on the balance of special damages incurred as totalled at the end of each six-month period following the notice in writing referred to in clause (1)(b) and at the date of the order.

Exclusion

(3) Interest shall not be awarded under subsection (1),

(a) on exemplary or punitive damages;

(b) on interest accruing under this section;

(c) on an award of costs in the proceeding;

(d) on that part of the order that represents pecuniary loss arising after the date of the order and that is identified by a finding of the court;

(e) where the order is made on consent, except by consent of the debtor; or

(f) where interest is payable by a right other than under this section. R.S.O. 1980, c. 223, s. 36.

Application

(4) Where a proceeding is commenced before this section comes into force, this section does not apply and section 36 of the Judicature Act, being chapter 223 of the Revised Statutes of Ontario, 1980, continues to apply, notwithstanding section 187.

The prejudgment interest rate as defined in section 137(1)(d) means:

> the bank rate at the end of the first day of the last month of the quarter preceding the quarter in which the proceeding was commenced, rounded to the next higher whole number where the bank rate includes a fraction, plus one percent.[30]

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[30]The main difference between the interest provisions of the Judicature Act and the Courts of Justice Act is that the present statute uses the bank rate whereas the former statute used the prime rate. There was a practical difficulty in using the prime rate because the Bank of Canada Review is not published until some time after the prime rate is set. The bank rate can be determined immediately.

The Court also has a discretion to vary or disallow prejudgment interest in appropriate circumstances. Section 140 of the Courts of Justice Act provides:

> 140. The court may, where it considers it just to do so, having regard to changes in market interest rates, the circumstances of the case, the conduct of the proceeding or any other relevant consideration,
> (a) disallow interest under section 138 or 139;
> (b) allow interest at a rate higher or lower than that provided in section 138 or 139;
> (c) allow interest for a period other than that provided in section 138 or 139,
> in respect of the whole or any part of the amount on which interest is payable under section 138 or 139. R.S.O. 1980, c. 223, ss. 36(6), 37(2).[31]

Prejudgment interest was introduced to encourage early settlement and payment of claims.[32] Some insurers now argue that the pendulum has swung the other way, from delays by defendants to delays by plaintiffs. They complain that the present prejudgment interest provisions give plaintiffs a disincentive to early settlement. Insurers also complain they are required to pay prejudgment interest, even for the period when they did not have sufficient medical information to evaluate or pay the claim itself or even to make a settlement offer. It was with these concerns in mind that the C.B.A.O., among others, recommended that, in actions involving bodily injury, prejudgment interest with respect to non-pecuniary

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[31] S.O. 1984, c. 11, s. 140. The bank rate is defined in section 137(1)(a) as: "the bank rate established by the Bank of Canada as the minimum rate at which the Bank of Canada makes short-term advances to the chartered banks".

[32] See Spencer v. Rosati, 50 O.R. (2d) 661 at 665 (per Morden, J.A.).

losses should not commence until the plaintiff has disclosed to the defendant or his insurer the extent and nature of the injuries sustained.[33] In the alternative, the C.B.A.O. recommended that prejudgment interest not commence until the plaintiff had agreed to make himself available for a medical examination on reasonable notice.[34] These recommendations were adopted by the Ontario Task Force on Insurance in a somewhat qualified way having in mind the comments which appear at page 59 of the Task Force Report.[35]

One cannot consider legislative changes to the prejudgment interest provisions of the Courts of Justice Act without first considering what purpose should be served by prejudgment interest. There are two possibilities; one is to compensate the plaintiff; the other is to provide an incentive to settlement.[36]

The compensation rationale for prejudgment interest is based on the guiding principle which governs the measure

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[33] See C.B.A.O. submission to the Minister of Financial Institutions in response to the Report of the Ontario Task Force on Insurance (July 30, 1986) Appendix B, pp. 7-12.

[34] See C.B.A.O. Submission. Insurers also argue that the delays exacerbate their difficulties in setting reserves.

[35] See the Ontario Task Force on Insurance, Final Report (1986), p. 59.

[36] See Bruce Feldthusen, Research Paper, prepared for the O.L.R.C. Project on Compensation (1987). A third possibility is that prejudgment interest is for payment of a just debt improperly withheld. See e.g., Toronto Railway Company v. Corporation of the City of Toronto, [1906] A.C. 117 at 120. But this objective can only be subsidiary to the compensation objective.

of damages in tort law; the victim should be restored as far as money can do to the position he or she would have been in if the tort had not been committed. Full application of that principle requires that the plaintiff be compensated for the loss of use and loss of value of a monetary award until such time as it is paid.[37]

I consider that compensation of the victim should be the main objective of prejudgment interest. As a general proposition, once it is accepted that the main purpose of prejudgment interest is compensation, then the interest provisions themselves should have a neutral effect on incentives to settle, favouring neither plaintiffs nor defendants.[38] I recognize that prejudgment interest was first introduced in order to promote early settlement or to discourage delay by insurers. I do not believe that the settlement incentive purpose should dominate, nor do I think it should be ignored. Unreasonable delays in the delivery of medical information, for example, should be dealt with by the exercise of the court's discretion as to costs and its discretion to vary or disallow prejudgment interest under section 140 of the Courts of Justice Act.

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[37]Equally, the defendant has had the use of the money over that period. In Riches v. Westminster Bank Limited, [1947] A.C. 390, Lord Wright stated at 400:

> The essence of interest is that it is a payment which becomes due because the creditor has not had his money at the due date. It may be regarded either as representing the profit he might have made if he had the use of the money, or conversely the loss he suffered because he had not that use. The general idea is that he is entitled to compensation for the deprivation.

[38]See O.L.R.C., Report, Vol. II (1987), p. 460.

With these principles in mind, I turn now to the specific elements of an award of prejudgment interest:

(a) The Date From Which Interest Runs

Section 138 provides that prejudgment interest on a liquidated claim runs from the date the cause of action arose; on an unliquidated claim prejudgment interest runs only from the date the person entitled gave notice in writing of his claim to the person liable.[39] If the primary purpose of prejudgment interest is to compensate, then the date when notice in writing was given is of no significance. I recommend that in the case of both liquidated and unliquidated damages, prejudgment interest in respect of personal injury awards should be assessed from the date of loss -- the date the cause of action arose. A similar recommendation has been made by the O.L.R.C.[40] Further, prejudgment interest payable in circumstances where SEF 44 underinsured coverage is responding to the claim should run from the date of loss rather than from the date of notification as is now provided in the SEF 44 endorsement. So long as the SEF 44 endorsement remains optional, this recommendation is something which should be discussed with the insurance industry.

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[39] The existing provision is designed to induce timely claims.

[40] See O.L.R.C. Report, Vol. II (1987), pp. 463-4.

(b) Simple or Compound Interest

Section 138(3)(b) of the Courts of Justice Act excludes compound interest. The exclusion is inappropriate. If the victim had the money, he or she could have invested it and thereby earned compound interest. While the defendant holds the money, compound interest is likely to be earned. Compound interest, in the words of the British Columbia Law Reform Commission, "reflects more accurately the operation of the marketplace and more fully and accurately measures the cost of delay to the successful plaintiff".[41] Accordingly, I recommend that section 138 of the Courts of Justice Act be amended to permit compound interest, calculated at quarterly intervals, to be awarded. This recommendation also has been made by the O.L.R.C.[42]

(c) Rate of Interest

The prejudgment interest rate is 1% above the bank rate. Some insurers argue that this rate is too high because of the restrictions on the type of investments they may make. The prejudgment interest rate is roughly equal to the rate charged prime corporate borrowers, but below the borrowing rate for individuals. The defendant has the use of funds that will be awarded from the date of the accident to the date of the judgment and, if the defendant makes short-term investments prior to judgment,

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[41] Law Reform Commission of British Columbia, Report on the Court Order Interest Act, (Vancouver: The Commission, 1987), p. 31.

[42] See O.L.R.C., Report, Vol. II (1987), pp. 468-9.

the defendant will likely earn a rate of return in the range of 2% less than the prejudgment interest rate. To that extent, the defendant is disadvantaged. But victims who must borrow in order to meet expenses caused by the accident are also disadvantaged as are victims who could earn greater than the prejudgment interest rate on riskier investments.[43] On the other hand, the current prejudgment interest rate is generally higher than the rate of return that can be earned by individuals on short-term investments. To that extent, some plaintiffs who have not borrowed may be overcompensated. No formula can precisely cover each individual case. The O.L.R.C. Report has recommended that the appropriate prejudgment interest rate should be the average bank rate. I think that is a reasonable compromise.[44] On the whole, it is neutral as between plaintiffs and defendants. The O.L.R.C. has also recommended that the prejudgment interest rate should be adjusted quarterly,[45] and that a fractional rate should be rounded, either up or down, to the nearest tenth of a point (rather than rounding up to the next full point which is the present requirement).[46] Both of these recommendations are sensible and I endorse them.

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[43] See Rea, An Economic Perspective.

[44] O.L.R.C., Report, Vol. II (1987), pp. 465-7.

[45] In cases where the rate has varied over a wide range in the period of entitlement to prejudgment interest, trial judges have averaged the rate. Provided there is sufficient reason, the Court of Appeal has approved the practice. See Borland v. Muttersbach, 49 O.R. (2d) 145 (trial); 53 O.R. (2d) 129 (C.A.); Dugdale v. Boissneau (1983), 41 O.R. (2d) 152 (C.A.); Howes v. Crosby (1984), 45 O.R. (2d) 449.

[46] O.L.R.C., Report, Vol. II (1987), pp. 467-8.

(d) Interest Rate on Non-Pecuniary Damages

The market rate of interest reflects two components: the rental value of money (the real rate of return) and the declining purchasing power of money (the inflation rate of return).[47] Some have argued that to allow interest on non-pecuniary damages at the statutory prejudgment interest rate overcompensates the plaintiff. The argument is applicable in all cases but is invariably made in the context of catastrophic loss cases.

In 1978, the Supreme Court of Canada established a rough upper limit of $100,000 for non-pecuniary damages.[48] Three years later in Lindal v. Lindal,[49] the Supreme Court of Canada accepted the proposition that the $100,000 was subject to increase due to inflation. With the declining purchasing power of the dollar, the current rough upper limit is approximately $195,000. Therefore, if a court awards a victim $195,000 for an accident which took place in 1978 and also awards interest on that sum from 1978 at the prejudgment interest rate, it is suggested that the victim is being compensated twice for inflation or for the eroding value of money. Trial judges have taken different

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[47] In addition to loss of use and loss of value associated with inflation, economists suggest minor cost factors (e.g., administrative costs) influence interest rates. See Posner, Economic Analysis of Law (1977), p. 147.

[48] See Andrews v. Grand & Toy Alberta Ltd., [1978] 2 S.C.R. 229, etc.

[49] (1981), 129 D.L.R. (3d) 263. Dickson, J. selected as the date of measurement January 19, 1978 which was the date of the Court's judgment in the Trilogy.

positions on this issue. The double counting argument was accepted by Mr. Justice R.E. Holland in Graham v. Persyko[50] where he reduced the rate of prejudgment interest on the non-pecuniary damage portion of the award to 2.5%. In the subsequent case of Borland v. Muttersbach,[51] Mr. Justice Barr rejected the approach of Mr. Justice R.E. Holland and awarded prejudgment interest on non-pecuniary damages at the statutory rate. The Court of Appeal did not interfere with the decision of Mr. Justice Barr on this point.[52] Then in DeChamplain v.

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[50] (1984), 30 C.C.L.T. 85 where R.E. Holland, J. stated:

> It is clear, however, that my assessment carries an element of inflation with it. It is above the old upper limit. In these circumstances the award of $125,000 will bear interest at only two and a half percent from February 23, 1981 to the date of judgment.

[51] Borland v. Muttersbach, supra.

[52] A separate argument made in Borland v. Muttersbach and also in Spencer v. Rosati was that non-pecuniary damages in cases of serious personal injuries are designed at least in part to provide solace in the future and to that extent are damages for future pecuniary loss which should not bear prejudgment interest. The argument was rejected by the Court of Appeal for the following reasons:

> ...we think that this introduces an unnecessary complexity into the determination of interest which is at odds with the terms of the legislation. Even if part of a judgment for non-pecuniary loss is notionally to cover the future our law requires a single, once and for all, payment to be made now. We see no warrant for extending judicially the policy set forth in s. 36(5)(d) respecting future pecuniary loss.

(See Spencer v. Rosati, supra, per Morden, J.A. at 665, 666).

Etobicoke General Hospital,[53] Mr. Justice Montgomery took a third approach. He awarded the full prejudgment interest rate on the first $100,000 and 2.5% on that part of the general damage award that exceeded $100,000 due to inflation. He rejected the approach of Mr. Justice R.E. Holland as undercompensation and that of Mr. Justice Barr as overcompensation.

While any number of policy considerations may be brought to bear on this issue,[54] I consider that the central policy should be to provide full compensation to the victim, but not to overcompensate him. I also consider that whatever rule is adopted, it should apply to the less serious injury cases as well as to the catastrophic cases.

The first matter to be addressed then is whether there is overcompensation when the full prejudgment interest rate is awarded on the non-pecuniary damage portion of an award. The issue can be considered by first looking at the matter in historical terms. For the purpose of analysis, we can take the example of a catastrophically injured victim. That person would be entitled to $100,000 plus the inflation add on from January 19, 1978 to the date of the accident. That total amount should bear interest at the full prejudgment interest rate from the date of the accident until judgment because the plaintiff

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[53] (1985), 34 C.C.L.T. 89.

[54] See J.R. Morse, "Pre-judgment Interest: Entitlement to and the Rate on Non-Pecuniary General Damages in the Amount of the Rough Upper Limit Plus Inflation," Advocates' Qtly. 7 (1986-87): 337.

is entitled to the money as of the date of the accident. Were the courts to make awards in terms of historical prices[55] then the proper measure of compensation would be achieved by applying the statutory rate to the award. However, such an exercise would be impractical and unrealistic, especially in less serious cases. Judges and juries and, more importantly, those settling cases cannot be asked to roll back the clock in assessing non-pecuniary damages. 1988 assessments of non-pecuniary damages will be assessed in 1988 dollars regardless of the date of the accident.

Assessing non-pecuniary general damages in current dollars is consistent with the principle in Lindal and reflects the impact of inflation from the time of the accident to the time of judgment. Therefore, to award the statutory rate on the award for non-pecuniary general damages from the date of the accident overcompensates the plaintiff. The amount to which the plaintiff was entitled at the time of the accident has been inflated twice, once by the impact of the Lindal principle and again by the impact of that portion of the prejudgment interest rate attributable to the declining value of money.

As I view it, in order to avoid overcompensation, it is more appropriate to award prejudgment interest on the non-pecuniary damage component of an award at the "real rate of return", which is the difference between the market rate of interest (which can be taken to be the prejudgment interest rate) and the inflation rate. While

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[55] That is the value of an award at the time the cause of action arose (the date of the accident).

not perfect, this rule will best approximate the proper measure of prejudgment interest compensation for plaintiffs.[56] In cases where this rule does not produce a fair result, it will always be open to the trial judge to vary the award under section 140 of the Courts of Justice Act.

The next issue is whether such a rule is workable in less serious cases, having in mind that non-pecuniary damages are not to be assessed on a sliding scale.[57] The Ontario Court of Appeal has directed that trial judges are not to use the catastrophic injury case upper limit as a point from which non-pecuniary general damages of less seriously injured victims are scaled down. I think I can say with some confidence that trial judges conscientiously seek to apply this direction, as difficult as it may be to do so in practice. Even so, damage assessments in less serious cases are generally made with current dollar values in mind, and therefore implicitly carry an adjustment for inflation.[58] While the exercise is less

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[56] It could be argued that even this rule produces slight overcompensation. To use an example, assume a catastrophic accident took place in 1978 and was settled in 1983. Assume further the statutory interest rate in each year was 10% made up of a 7% inflation rate and a 3% real rate. If the plaintiff received $100,000 in 1978, that sum would be worth $150,000 in 1983. On the Lindal principle, the $100,000 award inflated to 1983 dollars would be $135,000. Therefore, if 3% is given on $135,000 from 1978 to 1983 the amount increases to approximately $155,000.

[57] Mulroy v. Aquascene (1982), 36 O.R. (2d) 653 (C.A.); Howes v. Crosby, supra.

[58] See R.E. Holland, J. in Graham v. Persyko, supra at p. 12. In Mitchell v. Mulholland (No. 2), [1971] 2 W.L.R. 1271 (C.A.), Widgery, L.J. said at 1284:

precise than in the catastrophic case, I am of the view that the rule I propose is still fair in the non-catastrophic cases.

Finally, there is the matter of the appropriate rate of interest. The O.L.R.C., which has also recommended using the real rate of return on damages for non-pecuniary loss, has proposed 2.5% which is the same rate as the discount rate prescribed in Rule 53.09.[59] The discount rate is used to calculate the present value of future pecuniary loss. The figure of 2.5% is one which reflects the long-term historical difference between the market rate and the inflation rate. A long-term rate is appropriate for discounting long-term future pecuniary loss. In my view, 2.5% is not appropriate for a prejudgment interest rate which will generally be applied for relatively shorter periods of time. Over the past decade the real rate of return has been in the range of

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> No one doubts that an award of damages must reflect the value of a pound sterling at the date of the award and conventional sums attributed to, say, the loss of an eye, have been adjusted upwards in recent years on that account. Inflation which has reduced the value of money at the date of the award must, thus, be taken into account.

[59] One of the Ontario Law Reform Commissioners, Earl Cherniak, dissented. In his view, there was no empirical evidence to suggest that awards less than the maximum were adjusted for inflation. He suggested that the experience of most counsel who practised in the area was to the contrary. As a middle ground he proposed:

(1) prejudgment interest for non-pecuniary damages at 2.5% only on the maximum award; and

(2) in all other cases, the formula used by Montgomery, J. in De Champlain v. Etobicoke General Hospital.

3.5 to 4%. It would, in my opinion, be reasonable to use a prejudgment interest rate in this range with provision that the rate be reviewed every four or five years to keep the rate in contact with relatively short-term reality. An alternative approach would be to publish the real rate of return annually and to use the annual figure in calculating prejudgment interest on non-pecuniary general damages.

Accordingly, I recommend that section 138 of the Courts of Justice Act be amended to provide that the non-pecuniary damage component of an award bear interest at the real rate of return and if a specified rate is used it should be in the range of 3.5 to 4% with provision for periodic review by the Rules Committee. I note that Alberta has adopted the same approach. There the legislated rate is 4%.[60] England as well has taken this approach.[61]

D. THE DISCOUNT RATE

In Ontario motor vehicle accident cases, damages for future pecuniary loss (whether for loss of future earnings or cost of future care) are generally awarded as a lump sum.[62] The court assumes that any lump sum award will be invested and earn interest from the date of

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[60] See Judgment Interest Act, S.A. 1984, c. J-O-5, s. 4(1).

[61] See Wright v. British Railways Board, [1983] 2 A.C. 733. See also Pickett v. British Rail Engineering Ltd., [1980] A.C. 136 and Birkett v. Hayes, [1982] 2 All E.R. 710 per Lord Denning.

[62] Periodic payments can only be made on the consent of the parties under s. 129 of the Courts of Justice Act.

receipt. If the court were simply to award the plaintiff a lump sum equal to his total future damages, the plaintiff would be overcompensated. Instead, the lump sum award has to be discounted to reflect the fact that the unused portion is capable of earning interest (or profits). Put another way, the time value of money must be taken into account.

In the Trilogy, the Supreme Court of Canada held that in order to avoid undercompensating the plaintiff the impact of inflation had to be taken into account in calculating the discount rate.[63] The Court indicated that the appropriate discount rate was the difference between the market (or nominal) rate of return on long-term investments and the projected long-term inflation rate or, in other words, the real rate of return. In Andrews, the Court used a discount rate of 7% to calculate the present value of the award for future pecuniary loss but said "the result in future cases will depend upon the evidence adduced in those cases".[64] That approach required expert economic evidence in every case on projected future inflation and interest rates and had the effect of increasing the time and expense of personal injury litigation.

To eliminate what was largely an unnecessary

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[63] Andrews v. Grand & Toy Alberta Ltd., [1978] 2 S.C.R. 229 at 254-259.

[64] Andrews v. Grand & Toy Alberta Ltd., p. 259.

exercise,[65] the Ontario Rules of Practice were amended in 1980 to provide a legislated discount rate of 2.5%.[66] The current provision is found in Rule 53.09 and provides as follows:

> 53.09 The discount rate to be used in determining the amount of an award in respect of future pecuniary damages, to the extent that it reflects the difference between estimated investment and price inflation rates, is 2.5 percent per year.

This rule was intended to reflect the historical difference between the nominal rate of interest on long-term investments and the rate of inflation. The Committee considering the discount rate issue concluded that over the 50 years preceding 1980 a 2.5% discount rate accurately reflected the long-term real rate of return.

Despite the language of Rule 53.09 and its predecessor, courts have on occasion departed from the specified rate.[67] In my view, this serves to undermine

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[65] Rea, "Inflation, Taxation and Damage Assessment," Can. Bar Rev. 58 (1980): 280.

[66] Supreme Court of Ontario Rules of Practice, R.R.O. 1980, Reg. 540, Rule 267a. The rule was enacted following a recommendation by a special committee. See Report to the Committee of the Supreme Court of Ontario on Fixing Capitalization Rates in Damage Actions (February 1980).

[67] See, for example, McDermid v. The Queen (1985), 53 O.R. (2d) 495, where the Court departed from the rule and applied a different discount rate because the evidence indicated that the short-term real rate of interest was substantially higher than 2.5%. In Davies v. Robertson, 5 O.A.C. 393 a rate of 2% was used since it was intended to reflect productivity and accordingly was not a departure from Rule 53.09.

the very purpose of a fixed rate. I endorse the following observations by O'Leary, J. in Crew v. Nicholson:[68]

> For the Court to adopt a discount rate other than two and a half percent is to invite a return to the same kind of speculation that existed before Rule 53.09 and its predecessor was introduced. The drafters of the rule knew it would not always accurately reflect the real return on capital over certain periods. It will always be possible to show that for a period in the past the 2.5% rate has not been accurate, and so to predict that it is unlikely to be accurate for some period in the future. That kind of speculation and uncertainty the rule was designed to eliminate.

While I think Rule 53.09 should be applied in every case, and while at present there is nothing to suggest a rate other than 2.5%, it seems to me it would be useful if a mechanism were in place to review the appropriateness of the discount rate from time to time. I note that the O.L.R.C. has recommended regular review of the discount rate by the Rules Committee at least every four years.[69] Given that the discount rate is intended to be a long-term rate, review every four years may be unnecessarily frequent. On the other hand, review at relatively short intervals might lend legitimacy and credibility to the rate that is actually used and therefore provide a disincentive to litigants to lead evidence as to a different rate in a particular case.

E. GROSS-UP, STRUCTURED SETTLEMENTS, PERIODIC PAYMENTS

Lump sum awards for future care costs and pecuniary losses of dependants in fatal accident cases have to be

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[68] (1987 unreported).

[69] O.L.R.C., Report, Vol. II (1987), p. 510.

increased to take into account the impact of taxation.[70] This exercise is referred to as gross-up. If future care costs were paid periodically as incurred, gross-up would not be a factor. Gross-up is necessary only because compensation is made on a lump sum basis, and income generated by the investment of the lump sum is taxed. In fatal accidents, a dependant's pecuniary loss is determined by the deceased's after-tax income. Awards of damages for pecuniary loss in fatal accident cases must therefore be grossed up to ensure that full compensation is achieved.

The Trilogy[71] (particularly Andrews and Thornton) established the basis upon which future care costs in personal injury cases are to be assessed. The compensation model for future care costs involves an assessment of the injured plaintiff's future care requirements. These are determined by estimating the plaintiff's reasonable future care costs; the estimate is made without regard to any other resources the plaintiff may have available to meet those costs.

Two recent cases, Davies v. Robertson[72] and McErlean

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[70] In Fenn v. City of Peterborough (1979), 25 O.R. (2d) 399, the Ontario Court of Appeal first recognized the impact of taxation on the capital sum established for future care costs.

[71] Andrews v. Grand & Toy Alberta Ltd., [1978] 2 S.C.R. 229; Thornton v. Board of School Trustees of School District No. 57, [1978] 2 S.C.R. 267; Arnold v. Teno, [1978] 2 S.C.R. 287.

[72] (1984), 5 O.A.C. 393 (Ont. C.A.).

v. Sarel and the Corporation of the City of Brampton[73] illustrate the complexity of the gross-up calculation and the significance of the additional lump sum payment required to accommodate the concept of gross-up. The Ontario courts now consistently recognize that the fund established as compensation for future care costs in injury cases and for pecuniary losses in fatal accident cases will not be sufficient if the impact of taxation is not taken into account.[74] There is no uncertainty about this. The goal of full compensation cannot be achieved in lump sum awards of damages without engaging in the complicated exercise of gross-up. As Professor Waddams observed in reference to the Trilogy: "[I]n fact the whole tenor of the judgments is that the plaintiff's actual reasonable pecuniary losses should be fully compensated."[75] If future care costs and pecuniary losses in fatal accident cases are not grossed up, the plaintiff's actual reasonable pecuniary loss will not be fully compensated.

Many submissions to the Inquiry strongly recommend

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[73] (1985), 32 C.C.L.T. 199 (Ont. H.C.); reversed on appeal (Ont. C.A., 1987, as yet unreported).

[74] Future care compensation and pecuniary losses in fatal accident cases are generally not grossed up in Manitoba and British Columbia, although courts in both provinces recognize the reality of the tax impact on funds established for future care costs in injury cases. See MacDonald v. Alderson, [1982] 3 W.W.R. 385.

[75] S.M. Waddams, "Compensation For Non-Pecuniary Loss: Is There a Case For Legislative Intervention?" Can. Bar Rev. 63 (1985): 734.

that steps be taken to eliminate the need for gross-up.[76] Two solutions were repeatedly suggested: an amendment to the Income Tax Act (at least for future care costs) and mandatory structured settlements.

An amendment to the Income Tax Act is the best and simplest solution to the gross-up problem; this is unlikely to occur in the near future. I have consulted with officials at the Ministry of Finance and reviewed correspondence with the Minister on this issue. If the issue is to be addressed now, as it should be, it will have to be dealt with outside the perimeters of an Income Tax Act amendment. Nevertheless, I would hope that this issue will be given further consideration by the Minister of Finance.

A structured settlement is a means of paying an agreed future loss on a periodic basis. Revenue Canada's position on structured settlements has been made increasingly clear. Revenue Canada has defined a "structured settlement", and has provided guidelines making approval of structured settlement arrangements, on a case-by-case basis, unnecessary.

Revenue Canada Bulletin IT-365R2[77] defines a structured settlement as follows:

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[76]The I.B.C., C.B.A.O., Advocates' Society, F.A.I.R., all insurers making separate submissions and the Consumers' Association are among those supporting the elimination of gross-up.

[77]May 8, 1987.

> A structured settlement is a means of paying or settling a claim for damages, usually against a casualty insurer, in such a way that amounts paid to the claimant as a result of the settlement are free from tax in the claimant's hands.

Structured settlements have come to be identified with the periodic payment of damages by means of an annuity; the annuity is purchased by the defendant's casualty insurer from a life insurer. Annuity payments flow to the injured plaintiff as tax-free damages. The annuity contract is owned by the casualty insurer, which guarantees payment to the injured person. The increasing popularity of structured settlements is largely attributable to the cost of gross-up. Because periodic annuity payments flowing to the injured plaintiff are non-taxable, gross-up is not an issue.

In the settlement process, gross-up can be a bargaining tool. Although section 129 of the Courts of Justice Act permits the periodic payment of damages (and for that matter a review of damages), consent of "all affected parties" is required.[78] This provides plaintiff's counsel with enormous settlement leverage. For example, if counsel for all affected parties agree that compensation for a catastrophically injured plaintiff's future care costs will require a capital sum of $1,000,000, and that taxation of the investment will require a $500,000 gross-up, counsel may not settle the plaintiff's claim at $1,500,000, but rather agree to a structured settlement in which the gross-up savings of $500,000 is shared between the plaintiff and defendant.

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[78] S.O. 1984, c. 11, s. 129.

In this way, the plaintiff is paid an additional $250,000 (50% of the gross-up). Whether this $250,000 is used to fund enhanced annuity benefits or paid as up-front money is not important. The settlement can be said to be beneficial to both sides. The plaintiff's future care costs have been agreed upon and looked after through the structured settlement, and the plaintiff has also obtained an additional $250,000. At the same time, the defendant's insurer has paid $250,000 less than if the action had proceeded to trial without the plaintiff's consent to a structured settlement. Assuming that future care cost compensation was correctly established in the first place, the plaintiff is overcompensated. Because of this kind of settlement, the true, albeit indirect, cost of gross-up remains obscured.

Although gross-up is central to the structured settlement debate and the prevailing concern about insurance premiums, it is not the only issue. The very definition of a structured settlement raises the issue of periodic versus lump sum payments.

Periodic payment of damages was considered by the Committee on Tort Compensation (the Holland Committee) in 1980.[79] This Committee was established by the Chief Justice of Ontario as a result of the observations of Mr. Justice Dickson in Andrews v. Grand & Toy.[80] In that

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[79] Law Society of Upper Canada. Committee on Tort Compensation, Report, 1980. (Chairperson: The Hon. Mr. Justice Richard E. Holland). [Henceforth: Holland Committee, Report, (1980)].

[80] [1978] 2 S.C.R. 229.

case, Mr. Justice Dickson questioned the rationality of lump sum payments for future care cost compensation. The Holland Committee counselled caution in proceeding to a periodic payment regime, and recommended what is now known as a structured judgment, but only with the consent of the affected parties. After considering issues such as delay, rehabilitation, the capacity for inflation protection, the potential for dissipation of lump sum awards, O.H.I.P.'s involvement and even the injured plaintiff's sense of well-being and stability, the Committee rejected a periodic payment scheme. At page 24 of the Committee's Report, the following statement appears:

> For these reasons, we have rejected any general scheme of variable periodic payments that would be imposed on the parties against their will. However, we see no objection to the entering of a reviewable judgment on consent of the parties as has, in fact, been done in the past.

The Committee's recommendations led to what is now section 129 of the Courts of Justice Act. Section 129 provides:

> In a proceeding where damages are claimed,
>
> (a) for personal injuries; or
>
> (b) under Part V of the Family Law Reform Act, for loss resulting from the injury to or death of a person, the court may, with the consent of all affected parties,
>
> (c) order the defendant to pay all or part of the award for damages periodically on such terms as the court considers just;
>
> (d) order that the award for damages be subject to future review and revision in such circumstances and on such terms as the court considers just.

Because section 129 permits structured judgments, most view the section as a progressive step. Section 129 did not resolve the problem of gross-up or silence the debate about the relative wisdom of lump sum and reviewable periodic payment compensation schemes. The practical problem in section 129 is the need for consent.

The vast majority of submissions to the Inquiry were against gross-up, and most regarded the structured settlement as a convenient device through which gross-up could be avoided. Many academics seem to be less enthusiastic about structured settlements, partly because structures do not resolve the central issue - the availability of reviewable periodic payments particularly for future care costs.

Because a structured settlement involves the periodic payment of compensation, the issue of structured settlements often becomes merged with arguments in favour or against periodic payment of damages. The common law lump sum payment of compensation has many drawbacks. Chief among them is the difficulty of establishing with precision what amount of compensation will be required, perhaps years in the future. My mandate deals with compensation within a relatively narrow area, motor vehicle accidents, and it would be inappropriate for me to address the broad issue of lump sum versus periodic payments of compensation. Nevertheless, I think it is essential that the problem of the cost of gross-up be addressed; one way is through the use of a structured settlement.

There are other alternatives. Damages may be paid by insurers on a periodic basis. Professor Bale has proposed establishing a tort fund to accommodate periodic payments in the area of future care.[81] This fund would be established by the provincial government. Future care compensation would be deposited in the fund and paid out as the injured persons's future care needs arose. Future care costs would be subject to review. Gross-up would not be a factor as the fund would be government-run.

Professor Bale's proposal has much to recommend it, at least from the standpoint of avoiding gross-up, but some problems remain. First, in practical terms, a tort fund solution could not be implemented for years. Extensive consultation with the insurance industry, consumers' groups and the Bar would be required. Given the public's legitimate concern about automobile insurance premiums, a more immediate solution is required. Second, the tort fund concept involves the periodic reviewable payment of damages. A number of problems connected with establishing a review mechanism would have to be considered. Third, the tort fund requires an additional layer of government bureaucracy and this will inevitably be costly. The tort fund concept should be given further thought and study, but it is at best a long-term solution to a problem which requires immediate attention.

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[81] G. Bale, Cost of Future Care, Periodic Payments, Structured Settlements, Discounting, Taxation and Gross Up, Prepared for the O.L.R.C. Project on Compensation (1987); "Encouraging the Hearse Horse Not to Snicker: A Tort Fund Providing Variable Periodic Payments for Pecuniary Loss," in Issues in Tort Law/eds. F.M. Steel and S. Rogers-Magnet (Toronto: Carswell, 1983), p. 91.

A structured settlement has certain identifiable advantages over a pure lump sum future loss payment which is to be invested at a predetermined interest rate, usually 2.5%.[82] The benefits of a structured settlement are:

(a) Elimination of gross-up on pecuniary damages in fatal accident cases, and in compensation for future care in personal injury cases.

(b) Elimination of the plaintiff's investment risk; the annuity carrier assumes that risk.

(c) Elimination of the need to consider investment management costs as a separate issue; management fees become a non-issue.

(d) The annuity carrier assumes the risk that the plaintiff will live longer than the plaintiff's predicted, albeit impaired, life expectancy. Undercompensation because of longevity becomes a non-issue. This benefit applies to future care cost compensation.

(e) Although the plaintiff may dissipate annuity payments as they are received, dissipation of the capital sum is impossible if the settlement or judgment is structured. The likelihood of the state assuming responsibility for the plaintiff is diminished.

(f) The plaintiff's anticipated future needs can be taken into account in establishing the pay-out provisions of the annuity. The structure allows for flexibility both in the amount of individual payments and in their timing. While this flexibility exists, it ends once the annuity contract has been established.

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[82] This is the discount rate established by Rule 53.09.

(g) The amount of each periodic payment is established at the time of settlement. Their payment is certain; this is a stabilizing factor in the plaintiff's life.

(h) The injured plaintiff can participate in establishing the scheme through which his future care costs will be paid. A plaintiff entitled to pecuniary relief in a fatal accident case can also participate in establishing the structure.

(i) Inflation protection can (and should) be built into the annuity contract.

There are disadvantages. They include the following:

(a) Although the structure can be tailored to the expected needs of the plaintiff, future care compensation must be determined at settlement or trial.

(b) There may not be sufficient flexibility to deal with unforeseen expenses. This goes beyond the typical criticism of lump sum payments, namely, that they are not responsive to significant changes in circumstances. At least if a lump sum is available the injured person has the flexibility to encroach on that lump sum. In the case of a structure, that flexibility does not exist.

(c) There is a theoretical financial risk to the plaintiff. However, no life insurer has failed to deliver benefits to a beneficiary since Confederation. The plaintiff also has the benefit of the casualty insurer's guarantee.

(d) Some economists argue that denying lump sum compensation places the plaintiff in a position of economic disadvantage; the plaintiff will take less than full lump sum compensation to avoid periodic payments.[83]

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[83] Samuel A. Rea, "Lump Sum Versus Periodic Damage Awards," J. of Leg. Stud. 10 (1981): 131.

(e) The plaintiff loses flexibility because the annuity contract cannot be assigned, commuted or transferred.

A dominant concern with structured settlements is the uncertainty of the future. One cannot be certain as to how the plaintiff's future care cost requirements will develop, what costs will be incurred and when. It is possible, but not practical, to make the future care needs of an injured plaintiff subject to review. Finality and stability would be sacrificed. Enormous transaction costs would result from any review process. This issue obviously troubled the Holland Committee.[84]

Under the circumstances, I recommend that section 129 of the Courts of Justice Act be amended to provide for mandatory structured judgments at the discretion of the trial judge for future care costs and pecuniary loss in fatal accident cases. As a practical matter this would only apply in cases where the defendants are insured. Just as in the current system, the trial judge or jury will determine the plaintiff's future care costs as part of the required findings of fact. In fatal accident cases, the trial judge will make a finding as to a dependant's future pecuniary loss arising out of death. All affected parties may then give submissions on the structured settlement issue. If the trial judge is satisfied that lump sum compensation without gross-up should be paid, damages can be assessed in the usual way. If the trial judge, in considering the interests of affected parties and the public interest, is persuaded

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[84] Holland Committee, Report (1980), p. 24.

that the consequences of the taxation of a lump sum established for future care cost compensation or for pecuniary loss in fatal accident cases should be recognized, the trial judge may exercise discretion and impose a structured judgment. The parties should be given a reasonable but short period of time, such as 14 days, to consult with experts in structured settlements and, if necessary, with insurers writing impaired life annuities. The parties could then report to the trial judge and make submissions as to the form of the structured judgment for either or both future care costs and pecuniary loss in fatal accident actions. Inflation protection can be built into the annuity contract where appropriate.

If these recommendations are not implemented, or are delayed in their implementation, I recommend that in jury trials the gross-up calculation be made by the trial judge rather than the jury, after the jury has made findings of fact as to compensation which would attract gross-up. I do not think juries should be involved in the gross-up exercise. Calculating future losses is a difficult exercise; calculating gross-up is beyond the capacity of most juries.

Alternatively, we should proceed to establish a uniform predetermined basis upon which gross-up would be established.[85] Basic assumptions are made now on a case-by-case basis in the gross-up calculation exercise. If

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[85] The Court of Appeal both in Nielsen v. Kaufmann 54 O.R. (2d) 189 and in McErlean v. Sarel and Brampton (1987, unreported), suggested legislative reform was needed to achieve a measure of uniformity in the gross-up calculation.

gross-up is to remain with us, I would recommend that a subcommittee of the Rules Committee be struck to develop a uniform method to be used in all relevant cases for the gross-up calculation. This was the approach successfully undertaken in establishing the 2.5% discount rate (Rule 53.09).

The O.L.R.C. (with one dissent), after careful consideration of the periodic payment issue, recommended that:

> The law in Ontario should not be changed to accommodate a system of reviewable periodic payments that could be ordered by the court without the consent of the parties.[86]

While I agree with the O.L.R.C.'s rejection of the reviewable periodic payment of damages, I am still of the view that future care costs should be subject to periodic payment, in the discretion of the court. As noted by the O.L.R.C., and here, this can be done now, but only on consent.

Rejection of a mechanism for reviewing periodic payment of damages (a rejection I endorse) should not foreclose consideration of the periodic, non-reviewable payment of future care costs; periodic payments provide security and certainty for the injured, eliminate the cost of gross-up and avoid both investment risk and the risk of dissipation. This can be accomplished through a structured settlement. Although the solution is not

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[86]O.L.R.C., Report, Vol. II (1987), p. 403.

perfect, it is better and less costly than what we have now.

It is difficult to predict what cost savings will result from the elimination of gross-up. The Inquiry Claims Survey measured the current cost impact of gross-up at 0.4%. This significantly understates the true cost of gross-up. So few large cases proceed to trial that measurement of the cost of gross-up from that perspective is not helpful. The increasing use of structured settlements has masked the real impact of gross-up. There are relatively few claims in which gross-up is a factor, but when it is in issue, the amount of money at stake is significant.

Finally, as a general matter, the premium required to fund a structured settlement for any future loss is now less than the lump sum which has to be established (usually at 2.5%) to provide compensation for that loss. This arises because annuity carriers use an interest rate higher than 2.5% in establishing annuity premiums. What this means is that it costs less to fund a structured settlement (through the payment of an annuity premium) than it does to create a capital sum using the 2.5% discount rate.

Some have suggested that the court should have discretion to impose a structured settlement for loss of future income.[87] However, the arguments in favour of mandatory structured settlements for loss of future income

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[87] The submission of McKellar Structured Settlements Inc., is one example.

have considerably less force than for future care costs in that gross-up is not a factor as long as we assess future income loss on a before tax basis. I do not, therefore, go so far as to recommend that the court be given a discretion to impose a structured settlement for future income loss.

F. COLLATERAL BENEFITS

In Boarelli v. Flannigan,[88] the Ontario Court of Appeal decided that collateral benefits should not be taken into account in assessing damages for loss of earnings or earning capacity in personal injury cases.

The rule in Boarelli v. Flannigan, which has come to be known as the collateral source rule, is still the law in Ontario.[89] In Ontario, the collateral source rule covers virtually every collateral benefit, regardless of nature or source and whether or not a statutory right of subrogation exists. Accordingly, welfare benefits, unemployment insurance benefits, private accident insurance benefits and benefits under employee short-and long-term disability programs are all covered. Many have urged change.[90]

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[88] [1973] 3 O.R. 69.

[89] The principle has been approved by the Supreme Court of Canada in two fairly recent cases: Canadian Pacific Ltd. v. Gill, [1973] S.C.R. 654 (CPP benefits) and Guy v. Trizec Equities Ltd., [1979] 2 S.C.R. 756 (private employment pension benefits).

[90] See, for example, C.B.A.O. submission to the Minister of Financial Institutions (July 30, 1986) Appendix B, pp. 17-20; Bruce Feldthusen, Research Paper, For the Ontario Law

The principal argument made against the collateral source rule is that an injured person should not be permitted to recover more than once for the same loss.[91] In order to assess this argument, it is necessary to identify those collateral benefits which, when paid, result in overcompensation if the claimant recovers tort damages. I agree with Professor Feldthusen who draws a distinction between indemnity and non-indemnity payments.[92] An indemnity payment is one which is intended to compensate the insured in whole or in part for a pecuniary loss. Unemployment insurance benefits and employment disability benefits are examples of indemnity payments. A non-indemnity payment is a payment of a previously determined amount upon proof of a specified event, whether or not there has been pecuniary loss. Life insurance, employee retirement benefits and fixed-sum accident benefits are examples of non-indemnity payments. In principle, non-indemnity payments should not be considered in the discussion of the collateral source rule since they do not result in true overcompensation. Indemnity payments, on the other hand, can be clearly identified as duplicating an item of damage claimed from the tortfeasor and accordingly do constitute overcompensation.

Reform Commission Project on Compensation for Personal Injury and Death.

[91] A further argument can be made in terms of loss distribution and reallocation of losses. See O.L.R.C., Report, Vol. II (1987), pp. 423-6.

[92] Feldthusen, Research Paper.

If, in assessing full tort system compensation, the focus is on the plaintiff, the collateral source rule results in substantial overcompensation to Ontario motor vehicle accident victims taken as a group. In the absence of available data,[93] I thought it necessary to attempt to quantify the impact of the collateral source rule on bodily injury loss costs. Two bodily injury claims surveys and a comprehensive simulation dealing with the sources of compensation for motor vehicle accident victims were undertaken.[94] One of the two Inquiry bodily injury claims surveys was conducted to capture information on collateral source payments to accident victims and the extent to which those payments were taken into account, or not taken into account, in bodily injury claims payments. Thirty-five insurance companies, comprising approximately 90% of the Ontario automobile insurance industry, were asked to record collateral source data on every bodily injury liability claims file in the six-week period from April 13 to May 24, 1987. The insurers had to be asked to do this because they do not routinely record that information. Claimants with an income loss were divided into two groups, those with collateral sources of income and those without. 70% of the claimants fell into the latter group. The results of the survey indicated that when all sources of compensation were considered, claimants with collateral benefits received compensation for loss of employment income equal to approximately 136% of their gross wage loss. Those without collateral

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[93] No insurers have data on the extent to which bodily injury loss costs are increased because of the application of the collateral source rule.

[94] See Appendix III and Inquiry Research Study IV.

benefits received approximately 87% of their gross wage loss. Table 10.1 below shows, on a percentage basis, the breakdown by source of the amounts received by claimants with and without collateral benefits:

TABLE 10.1

	Amount received by claimants with collateral benefits	Amount received by claimants without collateral benefits
	% of gross wage loss	% of gross wage loss
Third party auto insurance company	70.2	63.5
Own auto insurance company	13.7	23.1
Own employer	36.5	-
Own health insurance company	8.6	-
Government benefits	6.8	-
TOTAL	135.8%	86.6%

The figures in Table 10.1 suggest that there is extensive overcompensation among accident victims with additional sources of income protection.[95] Some

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[95] Patricia Danzon, in a recent study of medical malpractice claims in the United States, concluded that statutes permitting or mandating the offset of collateral benefits reduced malpractice claims severity by 11 to 18% and claims frequency by 14% relative to comparable states without any collateral source offset. See P. Danzon, "The

explanatory comments are required. The base figure against which the various sources of wage loss compensation is measured is the motor vehicle accident victim's gross wage loss. It would, however, be a mistake to conclude that 100% of gross wage loss represents either the plaintiff's tort system wage loss compensation entitlement, or the plaintiff's wage loss compensation settlement demand. Plaintiffs entitled to compensation for wage loss (past and future) may have been guilty of contributory negligence. Moreover, compensation for lost income is not taxable. Some plaintiffs may, therefore, be willing to accept less than 100% of their gross wage loss, or less than whatever wage loss was payable as a result of contributory negligence. There is no way of quantifying the latter group, which I think may exist largely in the minds of economists. Contributory negligence, as related to the impact of the collateral source rule can, however, be assessed. I think it unlikely that those without collateral sources were, on average, any more or less contributorily negligent than those with access to collateral sources. If that assumption is correct, then we can use those claimants in Table 10.1 without collateral sources as the benchmark group for purposes of establishing a true aggregate wage loss entitlement. It would appear then from Table 10.1 that the real tort system aggregate wage loss compensation entitlement is 86.6% of gross wage loss. The reduction from 100% is mainly the result of contributory negligence.

Frequency and Severity of Medical Malpractice Claims: New Evidence," Law and Contemp. Problems 49, no. 2 (1986): 57.

Table 10.1 shows that those claimants with collateral sources received 135.8% of gross wage loss. Table 10.2 quantifies the extent to which those claimants receive loss of income compensation in excess of their tort law entitlement. Assuming that actual wage loss for claimants with collateral sources is $100, the Claims Survey tells us that compensation for tort and collateral sources equals $136. Furthermore, the survey also tells us that these victims are only entitled to $87. Thus, claimants with access to collateral source payments are being overcompensated by $49. How much more are these victims receiving than that to which they are entitled? Forty-nine dollars, as a percentage of entitlement ($87) equals 56%. Therefore, the 30% of victims with collateral sources are receiving 56% more (or half again as much) as their tort law-based wage loss entitlement. This results in an across the board aggregate overcompensation of 17% (30% x 56%). I may say that the 30% estimate of these with collateral sources, if anything, understates the true figure.

TABLE 10.2

135.8%	-	86.6%	=	49.2%
(actual compensation as a percentage of gross wage loss)		(actual entitlement as a percentage of gross wage loss)		(overcompensation as a percentage of gross wage loss)
49.2%	÷	86.6%	=	56.8%
(overcompensation as a percentage of gross wage loss)		(actual entitlement as a percentage of gross wage loss)		(overcompensation as a percentage of actual entitlement)

The results of the Inquiry Claims Survey are consistent with the results of a recent study of medical malpractice claims in the United States. In that study, Professor Patricia Danzon concluded that statutes permitting or mandating the offset of collateral benefits reduced the quantum of malpractice claims by 11 to 18% and claims frequency by 14% relative to comparable states without any collateral source offset.[96] Reduction in claims frequency is often ignored in the debate over the elimination of the collateral source rule. Any reduction in claims frequency can only be assessed in jurisdictions that have eliminated or modified the collateral source rule. Professor Danzon's American research in this area is thus particularly instructive.

Because of subrogation, instances of overcompensation should be relatively rare, at least in theory. Even in the absence of a statutory or contractual right of subrogation,[97] an insured who receives monies under a contract of indemnity is required to account to the subrogated insurer for money received from third parties to the extent that the money received exceeds the amount required for full indemnity.[98]

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[96] See Danzon, "The Frequency and Severity of Medical Malpractice Claims."

[97] Subrogation is really a creature of equity. It is an equitable right belonging to an insurer who has paid for a loss. See National Fire Ins. Co. v. McLaren (1886), 12 O.R. 682.

[98] Gibson v. Sun Life Assurance Company of Canada, [1984] L.R. 6758 (Ont. H.C.) In Glynn v. Scottish Union & National Insurance Co. Ltd., [1963] 2 O.R. 705, the

In practice, it appears that many collateral sources do not exercise their rights of subrogation. Employers consider the exercise of subrogation rights to be costly and, where recovery is attempted months or years after the benefit is provided, impractical. Employers are reluctant to subrogate because of employee relations considerations. Some sickness and accident carriers are of the view that the cost to establish and maintain a subrogation system outweighs the benefits to be derived from such a system.[99] Government departments do not often seek repayment of monies paid to accident victims under social welfare legislation. This is in part due to the cost of subrogation. It is also due to an absence of information as to whether subrogation rights exist. At the federal level, U.I.C. has no information about what is being paid to motor vehicle accident victims through the U.I. sickness/accident benefit. At the provincial level, the Ministry of Community and Social Services (COMSOC) has little or no information on what is paid to motor vehicle accident victims. In the end result, neither U.I.C. nor COMSOC knows whether it has a right of subrogation.

Overcompensation is inconsistent with the principles which govern the assessment of tort damages. It is

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Ontario Court of Appeal held that the right of subrogation arises, unless expressly excluded, in every contract of indemnity insurance. Subrogation does not arise from non-indemnity contracts of insurance unless expressly provided.

[99] Feldthusen, Research Paper.

incompatible with equity's concern with unjust enrichment. It is also costly.

Three arguments have been used to justify the collateral source rule. The first argument is that without the rule, the wrongdoer receives the benefit of the fortuitous circumstance that the accident victim had collateral benefits.[100] This argument focuses on the wrongdoer, whereas, in my view, the appropriate focus is on the victim's loss. The paramount objective should be to restore the injured person to the position he or she would have been in had the accident not occurred. The collateral source rule does not achieve this objective.

The second argument is that the collateral source rule is justified on grounds of deterrence.[101] It is argued that only by making the tortfeasor responsible for all of the victim's losses is the optimal amount of deterrence achieved. This argument may be sound in theory, but in practice the deterrent effect of the collateral source rule is likely to be, at its highest, trivial, particularly given the existence of compulsory liability insurance. If the tort system as a whole only achieves modest or marginal deterrence objectives, there can hardly be much deterrence in the collateral source rule.[102]

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[100] See, for example, Bourgeois v. Tzrop (1957), 9 D.L.R. (2d) 214, per Ritchie, J. at 224-5; Parry v. Cleaver, [1970] A.C. 1, per Lord Pearce.

[101] Rea, An Economic Perspective. This is the argument from the law and economics literature.

[102] See the discussion on deterrence in Chapter 12.

Moreover, deterrence does not justify double recovery, rather, it suggests the exercise of subrogation rights.

Finally, it is argued that without the rule the injured person is deprived of a benefit for which he has paid and bargained.[103] In my view, this argument misses the point. In the case of indemnity payments, what a person has paid for is insurance against specific pecuniary losses. What the insured gets is the security of having coverage should the loss occur and indemnity for the loss when it does occur. In short, when an injured person receives a collateral benefit in the nature of an indemnity payment, he receives exactly what he bargained for. There is no doubt that a defendant obliged to make payments to a person with collateral sources will pay less. On compensation principles that does not justify overcompensating a plaintiff who has received the benefit of collateral source payments.

Professor Denise Reaume, in a research paper for the O.L.R.C. project, defends the collateral source rule on the ground that the plaintiff is not simply entitled to compensation if the plaintiff has been the victim of a

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[103] Boarelli v. Flannigan at p. 79. In Shearman v. Folland, [1950] 1 All E.R. 976, the English Court of Appeal in refusing to deduct private insurance benefits stated:

> If the wrongdoer were entitled to set off what the plaintiff was entitled to recoup or had recouped under his policy, he would in effect be depriving the plaintiff of all benefit from the premiums paid by the latter, and appropriating that benefit to himself.

tort, but is entitled to compensation from the defendant because it is the defendant who tortiously caused the injury. The fact that the same event has also triggered a payment to the plaintiff from another source is, according to Professor Reaume, irrelevant. I find this argument unconvincing.

I am of the opinion that the collateral source rule as presently applied in Ontario is wasteful in practice and cannot be justified in principle. It ought to be changed. I make no apology for having taken cost into account. Those who pay automobile insurance premiums are paying for the collateral source rule as it relates to motor vehicle accident loss of income compensation. Most insureds have never heard of the collateral source rule (a fact that goes to dilute the deterrence argument); when they are injured in a motor vehicle accident they are surprised to learn they can be paid twice for the same wage loss.[104] Many right thinking people find the collateral source rule inappropriate from the general standpoint of compensation fairness. Were the collateral source rule to be eliminated, injured claimants would recover whatever wages they had actually lost and total savings to the system would be approximately $35 million. All of Ontario's insured drivers would pay approximately $7 less for automobile insurance.[105] In addition, there would be a positive premium ripple effect. Prejudgment

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[104] I make this statement from my own experience in dealing with clients injured in motor vehicle accidents.

[105] Estimate of J. Cheng, Eckler & Partners, based on Inquiry Claims Survey data. This is a conservative estimate.

interest would be reduced. Party-and-party costs paid on settlements would be less because costs are generally calculated on a percentage of the settlement amount. If first party no fault accident benefits are increased (and continue to be a third party offset) and if collateral benefits are taken into account so as to reduce the claimant's third party entitlement, many wage loss claims will never enter the tort system.

There are two main ways to effect a change in the collateral source rule. One way is to maintain the rule but provide for better exercise of subrogation rights. The second way is simply to abolish the rule.[106]

Subrogation is costly. Most importantly, to the extent subrogation rights are not exercised because of cost or other factors, the situation will remain the same as it is now. The right of subrogation does not mean very much if it is not exercised. In my view, even given full information, it is unlikely in most cases that subrogation rights will be exercised for cost and public relations-related reasons. It seems to me, therefore, to be inappropriate to develop a model for eliminating overcompensation caused by the collateral source rule which is premised on subrogation. If the collateral source rule is abolished subrogation rights will still exist and may still be exercised, however, infrequently. If those rights are exercised, the wrongdoer's insurer

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[106] Feldthusen, Research Paper. The O.L.R.C. suggests two other possible mechanisms for avoiding overcompensation -- a direction by the court to repay, and an independent cause of action by the source of the collateral benefit. See O.L.R.C., Report, Vol. II (1987), pp. 416-419.

will simply be required to pay the collateral source payor.[107]

The O.L.R.C. has recommended facilitating subrogation by the following proposal:

> Where an injured person has received an indemnity, or an ex gratia payment, in respect of any specific pecuniary loss claimed from a wrongdoer, the damages in respect of that loss should be held in trust for the collateral source. Moreover, the wrongdoer, or his or her insurer, should be entitled to make payment of such damages directly to the collateral source and should be entitled to receive a discharge of liability to the injured person, to the extent of such payment. Payment of such amount of damages should also include pre-judgment interest on the amount.[108]

It might be argued that this proposal internalizes costs to the motor vehicle accident insurance system. It is not clear to me that such internalization is preferable to allocating primary responsibility to first party sickness and accident insurers by abolishing the rule. Furthermore, I am doubtful the O.L.R.C.'s proposal will work in the real world. Claimants effecting a tort system

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[107] In his paper, Feldthusen sets out three possible models of distribution:

(i) the collateral source rule/no subrogation;
(ii) the collateral source rule/subrogation; and
(iii) no collateral source rule/no subrogation.

The risk of the second model is that in practice it will collapse into the first model. The O.L.R.C. adopts the second model with proposed mechanisms to increase its effectiveness. It may, however, be questioned whether these mechanisms would work in practice.

[108] See O.L.R.C., Report, Vol. II (1987), p. 432.

recovery now hold money in trust for collateral source payors who routinely choose not to exercise rights of subrogation. Recognizing this, I think it is unlikely that automobile insurers will frequently opt to pay the collateral source directly. In the end result under the O.L.R.C. proposal nothing will change. Claimants will continue to be overcompensated. I am generally in agreement with Professor Feldthusen's views that subrogation has to be looked at as a practical as well as an academic issue.

The abolition of the collateral source rule is the most effective and least expensive method for eliminating overcompensation. Collateral benefits should be deducted from the relevant components of the tort award. Subrogation, to the extent it occurred, would take place between the collateral source insurer and the tortfeasor (or the insurer).

The remaining consideration is whether the collateral source rule should be eliminated with respect to all collateral benefits, or only some of them. I exclude non-indemnity payments from this discussion. I also exclude gifts.[109] Collateral benefits in the nature of indemnity payments may be conveniently divided between benefits from public programs such as unemployment insurance and benefits from private or group contracts of insurance such as employment disability plans.

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[109] One could include voluntary payments by employers in the nature of salary continuation. The O.L.R.C. took into account all ex gratia payments in its proposal.

The case for the elimination of the collateral source rule is perhaps more compelling with respect to public benefits.[110] The purchase of government benefits is generally mandatory. An individual has no choice whether to obtain such insurance. Therefore, to permit overcompensation in respect of government benefits is particularly wasteful.[111] I think that the rule should also be eliminated with respect to collateral benefits from non-government sources for the reasons I have already outlined.

Accordingly, I recommend that the Government of Ontario enact legislation[112] which provides as follows:

1. That the collateral source rule be abolished;

2. That where an injured person receives collateral benefits in the nature of indemnity payments from either public or private sources, the amount of such payments (subject to income tax, where appropriate, as discussed below) be deducted from the relevant components of a tort award made to

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[110]The O.L.R.C. considered and rejected deducting publicly provided benefits because it was inconsistent with deterrence and because it questioned the desirability of transferring to the entire tax-paying public the cost of an activity carried on by only a portion of the public. See O.L.R.C., Report, Vol. II (1987), pp. 434-5.

[111]See Rea, An Economic Perspective.

[112]Legislation would be required to modify the common law rule in Boarelli v. Flannigan, supra.

the injured person so that there will be no overcompensation.

I further recommend that both the Government of Ontario and the Government of Canada conduct a review of their respective programs which provide income assistance in the event of an accident in order to determine:

(a) the amount of monies paid to persons injured as a result of motor vehicle accidents; and
(b) the extent to which rights of subrogation in respect of these payments are being exercised or are feasible.

There are two other matters which must be considered. First, regard must be had to the fact some collateral source payments are taxable and tort awards for income loss are not taxable. Thus, if the full amount of taxable collateral source payments is deducted from a tort award, the claimant with taxable collateral benefits will be in a worse net position than the claimant without collateral sources (or taxable collateral sources). This result would be unjust. Accordingly, I recommend that taxable collateral source payments be deducted net of tax. In its supplementary submission the I.B.C. recognized the problem created by taxable collateral source payments were the collateral source rule to be abolished. The I.B.C. recommended that a flat 20% tax factor be applied to reduce the collateral source offset. It seems to me that to resort to a predetermined tax rate makes sense in the interests of efficiency and consistency. The 20% flat rate proposed is relatively neutral. In its final

application it will work to the slight disadvantage of high income earners in receipt of taxable collateral source payments.

The second matter is the manner in which collateral source adjustments will be made for future income loss collateral source payments. The problem here is that the claimant's receipt of those future collateral source payments will always be a matter of varying uncertainty. To address this problem, I recommend that loss of future income be established and paid without collateral source offset, but that the claimant hold future collateral source payments in trust for the third party insurer, net of tax where applicable. While I recognize the possibility exists for claimants not to cooperate in ensuring continued collateral source coverage, I have sufficient faith in humanity to think this will not often happen.

G. JOINT AND SEVERAL LIABILITY

As a result of section 2 of the Negligence Act, when a plaintiff is injured as a result of the negligence of two or more persons, each person is jointly and severally liable for the plaintiff's damages.[113] In other words, as

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[113]R.S.O. 1980, c. 315. Section 2 provides as follows:

> 2. Where damages have been caused or contributed to by the fault or neglect of two or more persons, the court shall determine the degree in which each of such persons is at fault or negligent, and, where two or more persons are found at fault or negligent, they are jointly and severally liable to the person suffering loss or damage for such fault or

between the plaintiff and the defendants, any defendant found negligent is responsible for the entire amount of the plaintiff's loss regardless of that defendant's degree of fault.[114]

Recently, there has been considerable debate as to whether the rule of joint and several liability should be abolished or at least modified.[115] Much of the debate has turned on the question of basic fairness.[116] Those who support the abolition of the present rule argue that it is unfair to require any single defendant to pay damages which are disproportionate to that defendant's share of fault. In its most graphic form, a defendant who is only 1% at fault may have to pay 100% of the plaintiff's judgment if a co-defendant, although 99% at fault, is judgment-proof. For those who favour abolition of the rule, the usual reform proposal is that each joint

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> negligence, but as between themselves, in the absence of any contract express or implied, each is liable to make contribution and indemnify each other in the degree in which they are respectively found to be at fault or negligent.

[114] As between themselves, defendants, absent any agreement to the contrary, are liable to indemnify each other in the degree in which they are respectively found to be at fault or negligent.

[115] See, for example, Ontario Task Force on Insurance, Final Report (1986), pp. 55-56.

[116] See G.L. Priest, Joint and Several Liability: The Issues and Remaining Questions (Toronto: Ontario Law Reform Commission, 1987). - (Contribution Among Wrongdoers Project).

tortfeasor will be liable only in proportion to his own degree of fault.[117]

On the other hand, those who seek to preserve the present rule argue it is fairer that a wrongdoer, as opposed to the innocent plaintiff, bear the burden of another wrongdoer's insolvency.[118] The academic literature has taken the debate beyond the issue of fairness and has examined the rule from the perspectives of accident prevention and risk allocation.[119] There is

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[117]Variations on this basic reform proposal can be found in several American states. For example, under Michigan tort reform legislation, a public entity is responsible for its proportionate share of economic and non-economic damages. If a court decides the amount owed by one or more of the defendants is not collectible, a public entity would pay only a percentage of the uncollectible amount equal to its degree of liability. In Alaska, any party responsible for less than 50% of the total fault cannot be held liable for any damages equal to more than twice its percentage of fault. See Business Insurance (August 18, 1986).

[118]It may be said that the fairness argument for victims loses at least some force when the victim is contributorily negligent; however, the rule of joint and several liability still applies. See for example Menow v. Honsberger, [1970] 1 O.R. 54, aff'd [1971] 1 O.R. 129, aff'd [1974] S.C.R. 239. For a critique, see Lewis Klar, "Contributory Negligence and Contribution Between Tortfeasors," in Studies in Canadian Tort Law/ed. L. Klar (Toronto: Butterworths, 1977), pp. 163-165.

[119]William M. Landes and Richard A. Posner, "Joint and Multiple Tortfeasors: An Economic Analysis," J. of Leg. Stud. 9, no. 3 (1980): 517; Frank H. Easterbrook et al., "Contribution Among Anti-Trust Defendants: A Legal and Economic Analysis," J. of L. and Econ. 23, no. 2 (1980): 331; A. Mitchell Polinsky and Steven Shavell, "Contribution In Claim Reduction Among Anti-Trust Defendants: An Economic Analysis," Stan. L. Rev. 33 (1981): 447.

little empirical evidence available to assess the monetary impact of joint and several liability.[120]

Whether the practical concern over joint and several liability is justified in situations where one of the defendants has a "deep pocket" and the other is likely to be impecunious is outside the scope of this Inquiry.[121] I think it is fair to state that in the motor vehicle accident context, the rule is of limited concern. Ontario insureds have compulsory third party liability minimum limits of $200,000. Many have coverage in excess of that amount. The average third party liability coverage is about $500,000. Over 90% of insureds have underinsured motorist coverage (SEF 44). The risk of failing to collect on a judgment from the appropriate party or parties is much lower in the motor vehicle context than in other fields of tort law. In light of these observations, I see no sound reason to recommend any change to the present rule of joint and several liability. The issue deserves further study.

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[120] Priest, Joint and Several Liability.

[121] Concern over the application of joint and several liability has most often arisen in the case of "deep pocket" defendants such as municipalities, public utilities and professionals.

CHAPTER 11

ALTERNATIVE COMPENSATION SYSTEMS

I have considered a number of different proposals for reform of Ontario's automobile accident compensation system. Some were based on systems in place in other jurisdictions. Some were found on the pages of law review articles or in textbooks. Still others involved making various modifications to the existing system, without changing its basic structure.

The various alternative compensation schemes may be conveniently identified as follows:

(i) the tort system;
(ii) the tort system, together with add on no fault benefits;
(iii) a pure no fault system for automobile accidents;
(iv) threshold systems;
(v) a comprehensive no fault system for all injuries caused by accidents or for all disabilities; and
(vi) other compensation proposals.

A. THE TORT SYSTEM

The tort system is now the principal and certainly the most generous method of compensating automobile accident victims in Ontario. One alternative is to make it the only method of compensation (aside from collateral, public and private schemes). Implicit in this alternative is the abandonment of compulsory no fault benefits now contained in Section B of the standard automobile insurance policy.

To the extent that individuals wished no fault disability coverage, they could purchase it on an optional basis, or look to private employment plans or public programs for protection in the event of injury as a result of a motor vehicle accident.[1] No fault benefits have been firmly in place in Ontario since 1972. It would, in my view, be a retrograde step, not justified by current social policy or by any substantial cost savings, to revert to the system in place in this province in the 1960s.[2] Accordingly,

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[1] One argument against compulsory first party benefits is that many people already have good, basic protection in the event of short-or long-term disability by way of employee plans. It is argued that to require these individuals to purchase first party insurance that they do not want and likely will never use is unfair and smacks of paternalism. By comparison, compulsory third party insurance is more defensible in that it is appropriate for governments to demand that one who breaks the rules of the road has the means to satisfy the plaintiff's judgment. See Richard A. Epstein, "Automobile No-Fault Plans: A Second Look at First Principles," Creighton L. Rev. 13 (1980): 769.

[2] No fault benefits are now relatively inexpensive. They provide necessary income and medical protection to those accident victims who are without other sources of first party insurance. If car owners were permitted the option of not purchasing these benefits, the cost for those who did require them would be excessive. See also S. Rea, "Economic Analysis of Fault and No-Fault Liability Systems," Can. Bus. L. J. 12, no. 4 (1987): 444 where the author examines possible economic justifications for compulsory first party insurance. Of the five possible arguments he considers (redistribution of income to the disabled, consumer underestimation of risk, adverse selection, a better society if the healthy know the disabled are compensated, and as a way to offset the disincentives to private insurance from the existence of government programs), Professor Rea concludes that only the adverse selection argument has merit. The argument is that if insurance is voluntary, high risk individuals will be most likely to buy insurance. The resulting increase in the cost of insurance may make insurance less attractive for low risk groups. Compulsory no fault

while I identify a return to the tort system as an available option, it is not one that I have seriously entertained.

B. THE TORT SYSTEM WITH ADD ON NO FAULT BENEFITS

This is the system currently in place in this province. It is also the system in place in every other province in Canada, save for Quebec. The standard automobile insurance policy issued in Ontario provides for compulsory no fault benefits paid on a first party basis; that is, by the insured's own insurer.[3] A person injured in an automobile accident is, subject to specifically defined exclusions, entitled to receive these benefits on a no fault basis. The details of these benefits have been discussed elsewhere. Suffice it to say here that they are quite modest. The Ontario no fault benefits are collectively referred to as Accident Benefits. The income replacement no fault benefits are referred to as Disability Benefits. The injured person's access to the tort system is in no way restricted by receipt of no fault benefits in an add on system. No fault accident benefits paid or available are deducted from any tort award.[4]

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automobile insurance would allow both groups to purchase insurance at average rates. I do not agree with this argument. If first party automobile insurance were not compulsory, high risk individuals and those needing the coverage most from an economic standpoint may be the least likely to buy it voluntarily.

[3] For a detailed analysis of the policy see J. Newcombe, The Standard Automobile Policy Annotated.

[4] See the Insurance Act, R.S.O. 1980, c. 228, s. 233(2). See Malat v. Bjornson, [1981] 2 W.W.R. 59.

The rationale for the introduction of no fault benefits in Ontario is somewhat unclear. They may have been introduced more to provide injured plaintiffs with some money to tide them over until the trial or settlement of their tort actions, than to provide basic protection to accident victims, regardless of fault. If Accident Benefits were designed to remove the minor injury cases from the court system, they have not had that effect. If anything, the availability of Accident Benefits has acted as a spur to litigation by removing some of the monetary pressure on plaintiffs to effect an early settlement of their claims.

There is no doubt that if the no fault benefits in an add on system, or otherwise, are to serve any useful purpose, they must be increased. Inflation alone would justify an increase in Accident Benefits. The level at which these benefits are set, however, will turn on what is sought to be achieved by compulsory first party benefits. There is general agreement that first party no fault benefits should at least ensure basic income maintenance, medical protection and access to rehabilitation without delay to all Ontario motor vehicle accident victims.

The automobile no fault benefits are not primary. Many insureds in the province are already covered for economic losses by short-and long-term disability programs and accordingly are being obligated to purchase a package of no fault benefits which they will not use at all, or to a very limited extent, in the event of a motor vehicle accident. The higher the level of benefits, the higher the cost. It may be questioned what increase in premiums can be justified for a coverage which is irrelevant to the

insurance needs of many who are forced to buy it. This goes to the fundamental issue of opting out. Another consideration is the percentage of cases that may be removed from the tort system if the no fault benefits are made more generous. A further consideration is whether eligibility for disability benefits should be expanded to compensate non-income earners. I will return to these and related issues in Chapter 12.

Those who favour add on systems argue that such systems preserve the best of both worlds. The delivery of reasonable no fault benefits ensures protection for income losses and medical expenses without delay for most victims. At the same time, access to fault-based compensation through the courts is preserved, not demolished as in pure no fault, nor diluted as in threshold no fault systems.[5]

C. PURE NO FAULT (MOTOR VEHICLE ACCIDENT COMPENSATION ONLY)

One option which must be given serious consideration is to abolish access to the tort system entirely for motor vehicle accident victims and replace it with a pure no fault system of compensation. The province of Quebec did so in 1978.[6] The Ontario Task Force on Insurance recommended that Ontario implement a no fault automobile

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[5] See Gary T. Schwartz, "The Advantages of Tort," in Personal Compensation for Injury. Proceedings of a Seminar on Personal Compensation for Injury Sponsored by the Faculty of Law, Australian National University, August 1984. Linden suggests that an add on plan reflects "the peaceful co-existence" of tort and no fault.

[6] Automobile Insurance Act, L.Q. 1977, c. 68.

insurance compensation system.[7] The majority of tort scholars both here and in the United States favour such a scheme,[8] although it seems to me the real preference of many of that group is for a comprehensive disability compensation plan.

Under a pure no fault system, the injured person loses the right to sue in tort entirely. Instead, compensation is paid solely on a first party basis, regardless of who is negligent or at fault in the accident. Generally, compensation takes the form of payment for income losses, medical and rehabilitation expenses and death benefits. A no fault system can also provide for compensation for non-economic loss. A no fault plan will inevitably have to compensate more injured persons than the tort system, those at fault as well as those not at fault; in order to fund such a plan without the cost being prohibitive, it is

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[7] See Ontario Task Force on Insurance, A Pre-Publication of the Final Report (1986), Vol. I, p. 105. The Task Force recommended that in the short term a no fault automobile accident compensation scheme should be implemented; as a medium-term objective, the Task Force recommended a universal accident compensation plan; and as a longer term objective recommended federal and provincial governments should begin planning the co-ordination and rationalization of all existing first party no tort compensation schemes into a universal disability compensation program. The Task Force Report used the descriptive term "no tort" as opposed to no fault. This seems to have been a matter of marketing, not substance.

[8] See e.g., Fleming, The Law of Torts. - 6th ed., Chap. 19, esp. pp. 370-371; Stephen D. Sugarman, "Doing Away with Tort Law," Cal. L. Rev. 73, no. 3 (1985): 558; Bernzweig, By Accident, Not Design; Ison, The Forensic Lottery; O'Connell, The Lawsuit Lottery (and numerous other writings); Dunlop, "No Fault Automobile Insurance and the Negligence Action," Osgoode H. L. J. 13, no. 2 (1975): 439.

generally thought necessary to reduce, if not eliminate, compensation for non-economic loss (pain, suffering and loss of enjoyment of life). If compensation for non-economic loss is provided (as is the case in Quebec and New Zealand), that part of compensation is established by schedule.

Two further observations are in order. First, whether to establish a no fault compensation plan is an issue which is quite separate from the issue of whether automobile insurance should be delivered by the government or by the private sector. Second, compensating the injured on a no fault basis does not necessarily mean that premium levels will be set without regard to fault. Some knowledgeable commentators in this field are of the view that an important unresolved issue under a no fault regime is how to set premiums.[9] If everyone in the system pays the same premium (as is the case in Quebec) there will be more high risk drivers on the road. This will inevitably lead to higher accident, injury and death rates. The data available from Quebec suggest this result.[10] Experience-rating, unlike flat premium rating, requires the commitment of resources to somehow allocate accident fault, if involvement in at-fault accidents is to be a premium rating factor. While premium setting is distinct from compensation, it is an issue that all no fault regimes must address. This issue will be addressed further in Chapter 12.

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[9] See for example, M.J. Trebilcock, Where do the Bucks Stop? (1987). (Unpublished).

[10] See M. Gaudry, Measuring the Effects of the 1978 Quebec Automobile Insurance Act with the DRAG Model.

Those who support no fault generally put forward the following main arguments:[11]

(a) Universal Compensation

A no fault system ensures adequate compensation for all injured victims of car accidents, not just those who can establish fault. At a time when it might be said that car accidents are an inevitable by-product of modern society, it is no longer appropriate to gear entitlement to compensation to the absence of negligence, or conversely, the presence of fault. The goal of universal compensation is compromised to the extent that any given no fault plan contains driver conduct-related exclusions.

(b) Guaranteed Protection for Economic Loss

A no fault system provides guaranteed basic protection against income loss and medical and rehabilitation expenses.

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[11] See Chapter 8. The arguments are set forth in Keeton and O'Connell, Basic Protection for the Traffic Victim (1965); Bernzweig, By Accident, Not Design (1980); Ison, "The Politics of Reform in Personal Injury Compensation," U. of T.L.J. 27 (1977): 385 and Keeton, "The Case for No Fault Insurance," Miss. L.J. 44 (1973): 1. In Cassidy v. McGovern, 415 Mich. 483 at 498-99, the Michigan Court indicated that no fault laws were designed to remedy the shortcomings of the traditional tort recovery system--overcompensation of serious injuries, long payment delays, overburdened court systems, and discrimination against those with low income and little education.

(c) No Delay

A no fault system provides benefits to the accident victim without excessive delay, and certainly far sooner than the tort system. It is argued that this is particularly important in the case of rehabilitation where early intervention is critical.[12]

(d) Greater Efficiency

A no fault system returns more of the premium dollar to accident victims because transaction costs are reduced. To the extent that non-pecuniary loss is not paid in a no fault system and is paid in the tort system, cost savings result; however, this is not an efficiency issue.

(e) Greater Accuracy of Assessment

A no fault plan has the capacity to provide for a more accurate assessment of a victim's future needs because it can be designed to deliver reviewable periodic payments over time. The tort system's lump sum payment necessarily requires a present prediction (which may well be wrong) about future compensable losses. Although the issue of periodic versus lump sum payments often arises in the context of the benefits of no fault automobile

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[12]A corollary point is that for effective rehabilitation it is important to develop a positive attitude in the victim stressing the achievements that can be made rather than the tragedy which has occurred. It is said a no fault system better accomplishes this objective because the victim no longer foregoes treatment in order to gain a higher damage award. See Dunlop, "No-Fault Automobile Insurance and the Negligence Action."

compensation, there is nothing to prevent legislation permitting reviewable periodic payments within the tort system.[13]

(f) No Loss of Deterrence

A no fault system loses nothing by way of deterrence or accident prevention. That task can be adequately handled by regulatory and criminal sanctions, driver experience-rated premiums and one's instinct for self-preservation. The Ontario Task Force on Insurance dealt with this issue by emphasizing the desirability of separating the deterrence function and the compensation function.

(g) Determination of Fault Unrealistic

Fault finding is an impractical criterion for compensation in motor vehicle accident cases. Not only, it is said, is it difficult to draw the dividing line between errors of judgment and true "fault" but, in practice, to use the late Dean Wright's phrase, "...the case that is actually tried by a jury is a case that never in fact took place..."?[14] It is argued that the negligence action is akin to a "forensic lottery".

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[13] See Chapter 10.

[14] C.A. Wright, "The Adequacy of the Law of Torts," in Studies in Canadian Tort Law/ed. A.M. Linden, 1968.

The Régie

Quebec is the only jurisdiction in North America that administers a separate plan on a complete no fault basis for the compensation of victims of automobile accidents. I have studied the Quebec plan and, to gain a better appreciation of how it operates, I have travelled to Quebec City and have spoken to some of those responsible for administering it, as well as to some of its critics and defenders.

In March 1978, the Parti Québecois introduced a new plan for compensating those injured in motor vehicle accidents.[15] The new plan abolished the existing Quebec fault-based system (which had very modest add on no fault benefits) and replaced it with a complete no fault system of compensation for bodily injury. Access to the courts was precluded. The plan is publicly administered and delivered by the Régie de l'Assurance Automobile du Québec,[16] a government board. The Régie, with control over its own budget, is virtually autonomous. It now reports to the provincial Minister of Transport. Premiums are reviewed by the Quebec Cabinet.

The Régie pays the following compensation to persons who sustain injury in an automobile accident:[17]

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[15] Automobile Insurance Act, L.Q. 1977, c. 68.

[16] An Act to Establish the Régie de l'assurance automobile du Québec, L.Q. 1977, c. 67.

[17] The Northern Territory in Australia has also done away with common law rights entirely for motor vehicle accidents. See Motor Vehicle Accidents (Compensation) Act, 1979.

(i) An income replacement indemnity, payable after a one-week waiting period and for so long as the disability lasts. The indemnity is indexed, not taxable, and is based on 90% of an individual's net income to a maximum gross income (as of January 1, 1987) of $35,500.[18] The maximum weekly indemnity now stands at $470. Even those not in the work force (persons at home, unemployed persons, retired persons and students) receive income replacement benefits;

(ii) Reimbursement for reasonable expenses incurred because of the accident;

(iii) Compensation to facilitate rehabilitation;

(iv) A lump sum indemnity in accordance with a pre-established scale for the after effects of the injury and pain and suffering or loss of enjoyment of life to a maximum of $39,329.13 for accidents occurring in 1987;[19] and

(v) In the case of fatalities, the Régie pays a lump sum death benefit ($8,046.48 as of January 1, 1987) or a pension (varying between $157.32 and $375 in 1987) where the victim has left one or

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[18] See the Régie, Annual Report, 1986.

[19] Régie, Annual Report, 1986.

more dependants. The Régie also pays $2,682.16 for funeral expenses.[20]

These benefits are primary. A claimant who is dissatisfied with the decision of a Régie claims administrator may apply to the Régie for a review. There is then a right of appeal to the Commission des Affaires Sociales,[21] whose decision is said to be final. I was told that, last year, there were approximately 35,000 claims to the Régie. The number of claims reviewed or appealed was not inconsequential. Of the 35,000 claims, there were 5,000 reviews and a further 2,000 appeals to the Commission des Affaires Sociales. Many reviews were over the question of non-economic loss.

The pricing of insurance in the plan involves a fixed premium for a given class of vehicle without regard to the driver's individual risk. The effect of flat premiums on accident frequency has been studied by Professor Gaudry. The results of his study are discussed in Chapter 12. Professor Gaudry found an increase in the rate of accidents, both for injuries and fatalities after the introduction of the Régie.[22] At my request, Professor

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[20] Régie, Annual Report, 1986.

[21] Discussion with Régie administrator in Quebec City, July 9, 1987.

[22] See M. Gaudry, Measuring the Effects of the 1978 Quebec Automobile Insurance Act with the DRAG Model. Gaudry estimated that the effect of the Régie was an increase in accidents of 6.8% for fatalities, 26.3% for injuries and 11.0% for property damage only.

Gaudry did a further study for the Inquiry [23] in which he examined in more detail the possible causes of the observed increases in accident rates. One of his conclusions was that flat premium rating resulted in cross-subsidization of high risk drivers. That conclusion is inescapable when high risk drivers and low risk drivers pay the same premiums. Professor Gaudry stated that in Quebec cross-subsidization has resulted in an increase in the total population of high risk drivers. This, in turn, has resulted in an increase in total accidents, bodily injury accidents and fatal accidents. Professor Gaudry is of the view that any sensible experience-based rating system would assist in correcting Quebec's accident frequency problem.

Vehicle damage claims remain outside the Quebec plan and are administered by the private sector. These claims have been removed from the court system because of the statutory provision that the insured is compensated for his property damage by his own liability insurer who indemnifies him directly under the liability section of the policy, to the extent that the insured is not responsible for the accident. Fault is determined by an internal insurance fault schedule. As provided by the statute, the insurers have established the "Corporation des Assureurs Agrées" which administers the "Direct Compensation Agreement" to which all authorized insurers must adhere. Resort to the fault chart does not dispense with the need to investigate fault in all cases. Before fault is determined through the fault chart, insurers have

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[23] See Inquiry Research Study I.

to determine how an accident occurred. This will sometimes require an extensive investigation.

Although politics likely determined its introduction, Quebec's no fault plan was not born in a vacuum. In 1973, the Gauvin Committee of Inquiry on Automobile Insurance reported that the existing fault regime had engendered high costs of insurance, long delays before obtaining compensation and, further, many victims with real losses were not being compensated either because they were at fault or because defendants' coverage was inadequate; in such cases, it was said defendants were often insolvent.[24] The Parti Québecois accepted the main compensation-related recommendations of the Gauvin Committee, but rejected the Committee's recommendation in favour of private sector delivery.

Some of the ills that led to the introduction of no fault in Quebec appear to have been addressed by the new regime. A recent study of the Quebec system by two University of Montreal economics professors, Claude Fluet and Pierre Lefebvre, released in February 1986, generally commented favourably on the reform.[25]

One of the things the Régie does particularly well is to provide rehabilitation. There are now some 35

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[24] See Ontario Task Force on Insurance, A Pre-Publication of the Final Report (1986), Vol. II, Appendix 12.

[25] See Excerpt from C. Fluet and P. Lefebvre, L'Assurance automobile du Québec: Bilan d'une Réforme, (February 1986) in Ontario Task Force on Insurance, A Pre-Publication of the Final Report, Vol. II, Appendix 13. The authors studied the results of the Régie during the period 1979-1984.

rehabilitation specialists working for the Régie, handling about 70 patients each. They deal with vocational rehabilitation, with the hospital side of rehabilitation being dealt with separately by the Quebec Hospital Plan. The Régie has statutory authority to stop payments if a person refuses rehabilitation without just cause.

Although the Quebec plan appears to be working reasonably well overall, there are signs of some dissatisfaction. This dissatisfaction is focused on the view that the seriously injured are not treated fairly. A series of amendments whose main purpose is to improve the lot of the more seriously disabled is now being considered by the government.[26] Under these proposed amendments, the maximum lump sum payment for non-pecuniary damage is to be increased from its present level of approximately $39,000 to $125,000. The latter figure is seen as being justified in light of the Trilogy. In order to receive any amount for non-economic loss the new proposals require that there be permanent physical or mental impairment by reason of the accident.[27] A one year whiplash, for example, would likely receive nothing for non-pecuniary loss under the proposed amendments.

In order to finance the sizeable lump sum increase that is proposed, premiums must go up or money must be taken from elsewhere in the system. The Régie chose to reduce existing benefits to the detriment of non-income

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[26] See Draft Bill: An Act to Amend the Automobile Insurance Act and Other Legislation 1987. [Henceforth: Draft Bill (1987)].

[27] See section 83.1 of the Draft Bill.

earners. Under the proposed amendments, non-income earners will get nothing for six months, at which time an estimate of future income loss will be made based upon capacity.[28] A victim who worked inside the home at the time of the accident will be entitled to an indemnity of $70 per week if unable to attend to the majority of tasks related to the care of cohabitants; an indemnity of $50 per week if unable to attend to the majority of tasks related to the preparation of meals; and an indemnity of $50 per week if unable to attend to the majority of tasks related to household maintenance.[29] Under the amendments, death benefits are to be decreased and paid in a lump sum rather than on a periodic basis.[30] The new amendments are estimated to require a net 4.5% increase in the Régie's budget. At the time of the writing of this Report, these proposed changes had yet to be enacted into law.

D. THE THRESHOLD NO FAULT

Under a threshold plan, first party no fault benefits are provided to all accident victims, but tort actions are only allowed above the "threshold". Apart from cost, thresholds seem to be designed either to keep less serious cases out of court, or to allow more serious cases into court. From a cost standpoint, the emphasis must be on

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[28] See sections 23-53 of the Draft Bill.

[29] Draft Bill, sections 34, 35.

[30] Draft Bill, sections 75ff. This reflects the notion that it is economically inefficient to deal with smaller claims in the tort system in that their nuisance value likely means they are overcompensated and in that transactions costs are relatively high in relation to the amount of the claim.

the savings which accrue by keeping claims below the relevant threshold out of court. Aside from reduced transaction costs, what is saved is the non-pecuniary general damages not paid in those cases which fail to meet the threshold. Costs, of course, are increased by the payment of economic loss on a no fault basis.

There are two basic types of threshold: monetary and verbal.[31] Under a monetary threshold, a victim is only able to maintain a tort action if, for example, the victim's medical expenses exceed $1,000. A verbal threshold is expressed in descriptive terms such as "serious impairment of body function" or "serious permanent disfigurement".

Inspired by the Keeton-O'Connell plan,[32] 18 states in the United States in the late 1960s to mid-1970s adopted threshold no fault plans for compensating automobile accident victims.[33] Enthusiasm for these plans south of the border appears to have waned. No new plans have been put in place in the last decade. Two states (Pennsylvania and Nevada) have abolished their threshold systems in favour of a return to unrestricted access to

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[31] Some jurisdictions, such as the state of New York, use what may be termed a "numerical" threshold, for example, days of disability.

[32] Keeton and O'Connell, Basic Protection for the Traffic Victim (1965).

[33] See J. Hammitt et al., Automobile Accident Compensation, Vol. 4: State Rules (1985). See also U.S. Department of Transportation, Compensating Auto Accident Victims (May 1985). The Northern Territory of Australia adopted a threshold plan in 1979 which is discussed in Fleming, The Law of Torts, pp. 373-4.

the tort system. At present, there are 16 states with threshold no fault plans. One state has a monetary threshold only;[34] 4 states have exclusively verbal thresholds;[35] and 11 states have a combination of monetary and verbal thresholds.[36] No state with a threshold provides first party benefits for non-pecuniary losses.

Monetary thresholds have the virtue of certainty. When expressed in absolute dollars, there can be little dispute as to whether an accident victim has or has not met the threshold. On the other hand, medical expenses incurred, for example, may not be a reasonable proxy for injury severity, or more importantly, disability. It is also argued that monetary thresholds are prone to abuse in that victims will pad their medical expenses in order to reach the threshold and gain access to non-pecuniary general damages.[37] In United States jurisdictions,

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[34] Puerto Rico. See U.S. D.O.T., Compensating Auto Accident Victims...Report (1985). We have counted Puerto Rico as a "state" for this calculation.

[35] District of Columbia, Florida, New York and Michigan.

[36] Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Massachusetts, Minnesota, New Jersey, North Dakota and Utah.

[37] For an opposing view, see the Rand Corporation study by Hammitt & Rolph, "Limiting Liability for Automobile Accidents: Are No-Fault Tort Thresholds Effective?" Law & Policy 7, no. 4 (1985): 493; Rolph et al., Automobile Accident Compensation, Vol. 1: Who Pays How Much How Soon?. The authors found no evidence of padding of medical expenses in states with monetary medical expense thresholds. The finding was based upon the absence of a disproportionate distribution of medical losses above the threshold. The finding has been questioned by O'Connell and Joost, "Giving Motorists a Choice Between Fault and No-Fault Insurance," Virg. L. Rev. 72 (1986) at p. 70 on the ground that the Rand study is based on states with

padding can take place in the number of visits to the hospital or the doctor's office and in the fee charged. Even though monetary thresholds have been relatively unsuccessful in the United States, it might be argued that they would work better in Ontario where one potential source of abuse is eliminated by the O.H.I.P. fee schedule and the ban on extra billing.

A verbal threshold has the advantage of better defining and establishing the kind of injury for which a victim might be able to sue for non-economic loss, but the general language in which a verbal threshold must inevitably be couched contains its own seeds of difficulty. Words such as "serious", "significant" or "permanent" are not always easy to apply individually and are even more difficult to apply in combination. This raises the concern about the additional costs associated with determining the application of the threshold. The experience (which I discuss below) in Michigan, a state considered by most to have the best threshold system in the United States, is at least a warning signal to those who would opt too readily for a verbal threshold plan.

Is there a principled rationale for a threshold system? What justification is there for permitting some accident victims access to the tort system, but excluding others? Cost and political considerations very much influenced the adoption of the threshold plans in the

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modest medical expense thresholds. O'Connell and Joost argue that in such states claimants may refrain from padding because it is unnecessary.

United States.[38] The Insurance Bureau of Canada proposal is a threshold plan, partly modelled on the Michigan system. It, too, was justified by I.B.C. representatives solely on the basis of cost, a way to provide reasonable compensation and, at the same time, keep insurance premiums from escalating further.[39] Apart from cost considerations, it might be argued that very seriously injured accident victims suffer such a reduction in the enjoyment of their lives that non-pecuniary compensation is warranted in order to provide them with some means of obtaining alternate sources of pleasure or satisfaction. On this theory, less seriously injured victims whose pain and suffering is transitory in nature do not require non-pecuniary compensation.[40]

Even if there is a defensible rationale for a threshold system, there remains the difficult problem of defining an effective and workable threshold. At least three important matters need to be considered. First, the

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[38] It was not just a matter of containing rising insurance premiums. Some argue that large damage claims were kept in the tort system in order to appease the powerful personal injury bar in the United States. Also, thresholds respond to the generally accepted wisdom that the less seriously injured are overcompensated. The constitutionality of threshold and no fault schemes is considered in Chapter 14.

[39] See I.B.C. Submission to the Inquiry; see also Transcript of Hearings, I.B.C. Oral Submission.

[40] See S.D. Sugarman, Serious Tort Law Reform (1987) (unpublished). There is of course much to be said for taking smaller claims out of the court system from an efficiency point of view. Conversely it is no doubt legitimate to say that if there is a public policy in favour of victim compensation, it should be in favour of the seriously injured.

threshold ought to be relatively easy to apply so as to provide a measure of certainty as to whether any particular claim is excluded. Otherwise, the transaction costs associated with determining whether the threshold is met on a case-by-case basis are likely to be excessive.

Second, in defining the threshold, there should be some thought given to the number of cases it is felt desirable to exclude from the tort system because of cost considerations.[41] For example, the I.B.C. claims that its proposed verbal threshold of "...death, permanent serious impairment of a body function or serious permanent disfigurement..." would exclude approximately 92% of cases from the tort system.[42]

The third and most important consideration (and it flows from the second) is that there must be an effective cost balance between the degree of restriction in access to the tort system and the level of no fault benefits. If generous no fault benefits are provided, but only relatively few tort actions are excluded, the result will be higher insurance premiums because the savings from reduced tort litigation will not be sufficient to finance the expanded no fault benefits. That is what happened in Pennsylvania. Its threshold plan, introduced in 1975, provided unlimited medical and rehabilitation benefits,

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[41] The reciprocal but non-cost related point which never seems to be addressed is the percentage of cases deemed serious enough to be let into the tort system. The consistent failure to address this issue reinforces my view that the fundamental rationale for threshold systems is cost.

[42] See I.B.C. Submission, pp. 13-15 and Exhibit II-18.

together with wage loss payments of $1,000 per month to a maximum of $15,000, all on a no fault basis. At the same time, accident victims could pursue a tort action if medical losses exceeded a mere $750.[43] Because the $750 threshold was rather easily met,[44] the result was an increase in car insurance premiums in Pennsylvania of about 20% per year.[45] Faced with the need to reduce costs, and hence control premiums, the Pennsylvania Legislature in 1984 opted to reduce no fault benefits and eliminate the threshold rather than further restrict access to the courts.[46] Pennsylvania now has a tort add on system similar to that of Ontario.

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[43] See U.S. D.O.T., Compensating Auto Accident Victims...Report (1985), p. 46. Pennsylvania No Fault Motor Vehicle Insurance Act, Pa. Stat. Ann. Tit. 40, sec. 1009.101-.701. There was a stricter verbal threshold as well. The monetary threshold was never increased despite inflation.

[44] Hammitt & Rolph, "Limiting Liability for Automobile Accidents: Are No Fault Tort Thresholds Effective?" estimated that the Pennsylvania threshold excluded 72% of cases.

[45] See O'Connell and Joost, "Giving Motorists a Choice Between Fault and No Fault Insurance" at pp. 65-66. The Alliance of American Insurers estimated that pure premiums in Pennsylvania were 53% higher than they would have been without the introduction of threshold no fault. See also U.S. D.O.T., Compensating Auto Accident Victims...Report (1985).

[46] See Pa. Stat. Ann. Tit., sec. 1701-1798. See also U.S. D.O.T., Compensating Auto Accident Victims...Report (1985), p. 46. There was apparently no real social or political interest in changing the no fault system to put it in better balance. It was decided simply to scrap it altogether.

The experience of New Jersey was even worse. Despite unlimited no fault medical and rehabilitation benefits, as well as wage loss payments to a maximum of $5,200, accident victims could sue in tort if medical expenses exceeded $200.[47] The result was an estimated 65% increase in pure premiums (or average loss costs per car) as compared to what the pure premium would have been without the threshold system.[48] Finally, in 1983, New Jersey amended its law. The statute now gives motorists a choice of a medical expense threshold of $200 or $1,500 and offers deductibles of $500, $1,000 or $2,500 for medical expense benefits.[49]

I turn now from these general observations about threshold systems to a more detailed examination of the Michigan system and to a brief discussion of the threshold plans in other American states.

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[47] See N.J. Stat. Ann, sec. 39.6A-8. Hammitt and Rolph estimated that the New Jersey threshold excluded only 48% of claims.

[48] See O'Connell and Joost, at p. 65 citing 1982 data from the Alliance of American Insurers.

[49] See U.S. D.O.T., Compensating Auto Accident Victims...Report (1985), p. 36; O'Connell and Joost, at p. 67 have criticized the present New Jersey law and suggest it is still seriously out of balance. Nevada too had an out of balance threshold system. Its threshold plan which went into effect in 1974 provided $10,000 in no fault benefits for each victim but had a tort threshold of only $750 in medical expenses. Sharp increases in insurance rates led to the repeal of the law in 1980. See U.S. D.O.T., Compensating Auto Accident Victims...Report (1985), p. 24.

(a) Michigan

Among threshold plans in the United States, Michigan's is often singled out as the most effective.[50] It was commented upon favourably by the Ontario Task Force on Insurance.[51] As I have already indicated, the I.B.C. proposal is modelled on the Michigan system. Accordingly, my staff and I spent considerable time inquiring into the operation of the Michigan threshold no fault law.

The Michigan plan came into effect in 1973.[52] It has a verbal threshold. The threshold is "death, serious impairment of body function, or permanent serious

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[50] The U.S. D.O.T., Compensating Auto Accident Victims...Report (1985) set out five criteria by which the effectiveness of a compensation system should be judged: (i) its cost in terms of average premiums; (ii) its benefits to auto accident victims; (iii) the speed with which it pays those benefits; (iv) the percentage of the premium dollar it pays to accident victims as benefits; and (v) the extent to which the system is in balance or not in balance. It would appear that the Michigan system rates higher than all other states according to these criteria. According to the DOT Report, its payment of 55.1 cents of every premium dollar to claimants ranked second to Maryland's 56.0 cents. Professor O'Connell is reported to have testified that Michigan's law is the "best no fault law in the world". See Michigan Trial Lawyers Association No Fault Task Force Brief, May 1987, p. 6.

[51] The only extensive reference to the Michigan threshold no fault plan is in an appendix to the Task Force Report. See Volume II, Appendix 14. The Task Force Report itself approached threshold no fault generally with considerably less enthusiasm. See Ontario Task Force on Insurance, Final Report (1986), p. 80.

[52] Mich. Comp. Laws Ann., sec. 500.3101, effective 10/01/73.

disfigurement".[53] In its application, the Michigan threshold is considered to be the strictest among all American states with threshold plans. It has been estimated that the Michigan threshold has excluded at least 90% of automobile accident cases from the tort system.[54] In turn, no fault benefits are relatively generous, and in fact provide a richer package than any other American threshold plan.

The Michigan no fault benefits include unlimited medical and rehabilitation expenses,[55] replacement of 85% of wage loss for three years to a current maximum of

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[53] MCLA 500.3125(1) provides:

> A person remains subject to tort liability for non-economic loss caused by his or her ownership, maintenance, or use of a motor vehicle only if the injured person has suffered death, serious impairment of body function, or permanent serious disfigurement.

[54] Hammitt & Rolph estimate 89% of cases are excluded. A 1981 study by AIRAC (All Industry Research and Advisory Committee closed claims study) estimated all but 6% of cases were excluded. One insurer, State Farm, estimated only 6-10% of its new claims contained a potential tort claim (See letter from State Farm to the Inquiry dated June 12, 1987). State Farm has also reported that in 1972, before no fault, it recorded 25.3 bodily injury liability claims per 10,000 insured cars. Under threshold no fault the rate had fallen to 1.9 by 1981. See No Fault Press Reference Manual. Michigan exclusion estimates at approximately 90% are to be compared or perhaps contrasted with the probable exclusion rate which will result if the I.B.C.'s proposed threshold were implemented. Clearly the I.B.C. threshold is more onerous than that of Michigan.

[55] The unlimited medical and rehabilitation benefits in the Michigan law caused problems for smaller insurance companies and led to the creation of a Catastrophic Claims Association to pay all losses above $250,000. See No Fault Press Reference Manual.

approximately $2,475 per month (the monthly indemnity is indexed to inflation), replacement services losses, survivor's benefits and funeral expenses. Access to the tort system for economic loss in excess of wage loss benefits is permitted whether or not the threshold has been met.[56] Collision damage is paid on a first party basis, save for a $300 deductible for which a so-called mini-tort action is available. The 1985 United States Department of Transportation study concluded that Michigan's no fault law was in balance in the sense that the threshold had reduced tort recoveries by an amount at least equal to the total payment of no fault benefits. The Department of Transportation study concluded, based on statistics computed by the Alliance of American Insurers, that the pure premium rates (as of 1982) were 17% lower in Michigan than they would have been without the advent of the Michigan law.[57]

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[56]See MCLA 500.3135(2)(c) and Cassidy v. McGovern, 415 Mich. 483 (1982), 330 NW 2d 22.

[57]See U.S. D.O.T., Compensating Auto Accident Victims...Report (1985), p. 34 for a summary of the Michigan system. The DOT conclusions on premium reduction have been criticized by Professor Priest, The United States' No Fault Experience and its Export to Canada (1987), a study done for the FAIR Committee. Priest makes the following points: (a) the DOT estimates do not include estimates of the changes in non-auto first party insurance costs that result from the adoption of a no fault plan. The increase on resort to non-auto first party compensation sources may account for the apparent reduction in auto insurance costs; (b) the extent of claim preclusion is not closely correlated with the estimates of no fault cost reduction; (c) the concept of no fault "balance", according to Priest, represents data manipulation because the balance definition makes no reference to the state's threshold level or benefit level.

Michigan's compulsory threshold plan has withstood constitutional challenge.[58] Of more immediate significance for my purposes, the definition and application of the threshold itself has been subject to varying judicial interpretation. In the cases immediately following the enactment of Michigan threshold no fault, the Michigan courts held that the issue of whether a plaintiff's injuries met the threshold was a question of fact for the jury. Only when the court found that reasonable minds could not differ on the application of the threshold did the issue become one of law for the court.[59]

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[58] Shavers v. Attorney General, 267 N.W. (2d) 72 (1978), cert. denied, 442 U.S. 934 (1979). In its decision the Michigan Supreme Court held that the compulsory threshold plan was in fact constitutional but that the rate-making mechanisms were constitutionally inadequate to assure that the required coverage would be available at fair and equitable rates. The Court also determined that Michigan drivers have a right to an explanation of how their individual rates are determined and a way to appeal decisions of insurance companies which they believe treated them unfairly. The Court gave the State Legislature and the Commissioner of Insurance until the end of 1979 to address the shortcomings in the auto insurance market. The result was the Essential Insurance Act which took effect January 1, 1981. That statute was held constitutional in Shavers v. Attorney General, 315 N.W. (2d) 130 (1982).

[59] See Advisory Opinion Re Constitutionality of 1972 PA 294, 389 Mich. 441 (1973), where the Court stated that the threshold of "serious impairment of body function" was language that could be easily understood and implemented by juries. As such, the question of whether an accident victim sustained a threshold injury should be a jury question unless no reasonable minds could differ as to the conclusion. See also, e.g., Harris v. McVickers, 276 NW (2d) 629.

Then, in 1982, in Cassidy v. McGovern,[60] the Michigan Supreme Court rejected its previous decisions and ruled that as a general proposition, the issue as to whether an injury is a serious impairment of body function is a question of statutory construction to be decided as a matter of law by the trial judge, not the jury. Only when there was a material factual dispute as to the nature or extent of the plaintiff's injuries was the matter to be submitted to the jury.[61] In Cassidy, the Court stated that the phrase "serious impairment of body function" was not susceptible to a simple definition; it did not attempt to define the phrase in its judgment. It gave the following important guidelines concerning the threshold:

(i) impairment of body function refers to impairment of an "important body function" [emphasis added];

(ii) while the threshold does not require permanent injury, permanency is relevant;

(iii) the Legislature intended an objective standard that looks to whether the injury affects a person's general ability to lead a normal life; and

(iv) the Legislature intended that the injury be objectively manifested.

Three main reasons were given by the Court for its holding in Cassidy. The phrase "serious impairment of body function" was not commonly used and, accordingly, the Court was of the view that juries would not have a clear

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[60] 415 Mich. 483 (1982).

[61] For a discussion of the Cassidy decision see R.M. Ransom and G.T. Sinas, "The Evolving No Fault Tort Threshold."

sense of its intended meaning; further, in the Court's view, the legislative intent was to reduce litigation in automobile accident cases and this would not be achieved if a trial was required in most cases; and, finally, uniformity as to what constitutes a serious impairment in the Court's judgment could be better achieved by trial judges than by juries.

The Cassidy decision undoubtedly had the effect of making it more difficult for plaintiffs to meet the threshold.[62] At the same time, by removing the threshold issue from the jury and allowing it to be determined by a trial judge on summary application, the Michigan Supreme Court likely removed an element of uncertainty from the system.

In January 1986, in DiFranco v. Pickard,[63] the Michigan Supreme Court reversed its holding in Cassidy. The decision in DiFranco returned the question of whether the plaintiff's injuries met the threshold to the jury, as long as it was one on which reasonable minds could differ. The Court in DiFranco also rejected the Cassidy guidelines of "important body function" and "objectively manifested injury", as well as the "general ability to lead a normal life" test. The Court's opinion stresses that the Legislature did not intend to limit recovery of non-

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[62] The Cassidy decision made it very difficult for any soft tissue injuries to meet the threshold. In the subsequent decision of the Michigan Court of Appeals in Williams v. Payne, 346 NW (2d) 564 (1984), the Court refined the Cassidy test to require that the injury be manifested "in a scientific or medical context" or be otherwise subject "to medical measurement".

[63] 427 Mich. 32 (1986).

economic damages to the catastrophically injured. The threshold "is a significant, but not extraordinarily high, obstacle to recovering such damages".[64]

One thing was made clear by our inquiries in Michigan. There has been considerable litigation over the application of the threshold. One lawyer told us there are more cases on the threshold issue than on the liability issue since, in most instances, the latter issue is relatively easy to determine. Whatever the merits of DiFranco, the uncertainty generated by that decision has made it almost inevitable that litigation over the threshold will increase. The insurance industry has become increasingly active in its efforts to persuade the State Legislature to do away with DiFranco and to restore the Cassidy standard.[65]

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[64] The Court held that the "serious impairment of body function" threshold contains two inquiries:

(a) What body function, if any, was impaired because of injuries sustained in a motor vehicle accident;

(b) Was the impairment of body function serious. The focus of the inquiry is not on the injuries themselves, but on how the injuries affected a particular body function. Relevant factors are the extent of the impairment, the particular body functions impaired, the length of time the impairment lasted and the treatment required to correct the impairment. An impairment need not be permanent to be serious.

[65] The proposed amendment states:

> A person remains subject to tort liability for non-economic loss caused by his or her ownership, maintenance or use of a motor vehicle only if the injured person has suffered death, serious impairment of body function or permanent serious disfigurement.

There is also a considerable amount of first party litigation, that is, litigation in which an insured sues his own insurers, usually over the non-payment of no fault benefits. This is to some extent to be expected because first party no fault benefits are relatively generous. Where there is more at stake, there is more to fight about. One Detroit law firm has seven lawyers who devote their practices exclusively to first party automobile insurance litigation. Interest penalties do not appear to have been a very effective deterrent to abuse of the first party system.[66]

There are other difficulties with Michigan's compensation regime. Michigan third party liability limits remain very low ($20,000/$40,000) by Canadian standards.[67] Thus, in a system where only serious cases

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> (a) serious impairment of body function means: an objectively manifested impairment of an important body function which affects the general ability to lead a normal life;
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> (b) permanent serious disfigurement means: an injury which impairs the beauty, symmetry or appearance of a person and renders it unsightly, misshaped or deformed in some manner.

The proposal includes a tighter definition of "permanent serious disfigurement" borrowed from the New Jersey statute.

[66] MCLA 500.3142. Overdue payments bear penal interest at the rate of 12% per annum. The amount may be significant to the claimant but is of little financial importance to the insurer.

[67] Where the minimum mandatory limits are $200,000.

("serious impairment of body function") are given a right to recover non-pecuniary damages, a successful plaintiff may well be claiming damages from a defendant who has third party insurance coverage of as little as $20,000. Having a substantially unpaid judgment is of little consolation to the injured.

There is also a significant problem in Michigan with uninsured motorists. It has been estimated that in the Detroit area 65% of motorists are uninsured; this includes motorists who obtain insurance but neglect to pay for it. In the end result, there are likely many more plaintiffs undercompensated or left with unsatisfied judgments than a cursory look at the system might suggest. Those who wish additional protection can of course acquire it through uninsured and underinsured first party coverages. Because third party minimum limits are so low, underinsured coverage is relatively expensive, particularly in urban areas such as Detroit. The high number of uninsured drivers makes uninsured coverage expensive as well.

The Michigan system is not without its virtues. The Michigan plan has performed very favourably in terms of the cost, benefit and balance analysis used by the United States Department of Transportation to analyze the effectiveness of state automobile insurance systems.[68] I was impressed with the way in which the system deals with rehabilitation, particularly in serious injury cases. Encouraged by unlimited first party rehabilitation

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[68] See U.S. D.O.T., Compensating Auto Accident Victims...Report (1985), esp. pp. 65-93.

benefits, a number of special rehabilitation centres have grown up in Michigan. They do a very effective job in an obviously important area. Mediation panels, which have become a regular feature of Michigan's pre-trial procedures, have been very successful and are, to an important extent, responsible for the fact that very few automobile accident cases actually come to trial.[69]

(b) Other Tort Thresholds

I also examined (in a less extensive way than was the case with Michigan) the threshold no fault systems in Florida, New York, Minnesota and Pennsylvania.[70]

Florida's threshold no fault law went into effect in 1972 with a medical expense threshold of $1,000. After its first year of operation, insurance costs began to rise much more quickly than inflation. There was a general consensus that the principal reasons for the cost increases were that the dollar threshold had been eroded

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[69]Michigan's effective use of mediation is unrelated to its threshold no fault plan.

[70]In addition to Michigan, only Florida, New York and the District of Columbia have purely verbal thresholds. Florida and New York changed from a dollar threshold to a verbal threshold in the late 1970s. The District of Columbia was ordered to do so by the United States District Court in Diamond v. District of Columbia. The Court held that the $5,000 medical expense threshold "establishes an arbitrary and irrational classification between accident victims whose medical expenses exceed $5,000 and those whose expenses fall below that threshold amount".

by inflation[71] and that some claimants exaggerated their claims in order to overcome the restriction on the right to sue.

In 1976, the Florida Legislature amended its law to provide a verbal threshold only:

> death, significant and permanent loss of an important body function, injury that is permanent within a reasonable degree of medical probability other than scarring or disfigurement, or significant and permanent scarring or disfigurement.

Florida provides only a maximum of $10,000 per victim in no fault benefits. Given the strictness of Florida's threshold,[72] it is not surprising that the Alliance of American Insurers found a 21% decrease in average loss costs (pure premiums) compared to what they would have been without the threshold.[73]

In 1977, the New York State Legislature abandoned its $500 medical expense threshold. It was thought this

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[71]Most dollar thresholds have not provided for automatic adjustment of the dollar values for inflation (Hawaii is an exception). See U.S. D.O.T., Compensating Auto Accident Victims...Report (1985), p. 93.

[72]Although Michigan is generally thought to have the most onerous verbal threshold, in its form Florida's verbal threshold is more stringent than that of Michigan. The crucial difference between the two thresholds is Florida's introduction of the qualifying word "permanent".

[73]See U.S. D.O.T., Compensating Auto Accident Victims...Report (1985), p. 100. In Florida, third party liability coverage is not compulsory. Only first party benefits are compulsory. The Florida no fault law came into being for its own pecuniary reasons. Primarily there was a political and social concern to force people to protect themselves since there was no political will to force drivers to protect others.

threshold would eliminate between 80 and 85% of tort claims; as it turned out, minor personal injury claims exceeded the threshold. The low dollar restriction became a target, encouraging excessive use of medical services and hospital facilities. New York's exclusively verbal threshold came into effect in December 1977.[74] It is considerably more detailed than most verbal thresholds. The language of the New York statute is as follows:

> (a) Death, dismemberment, significant disfigurement, a fracture, permanent loss of use of a body organ, member, function, or system, permanent consequential limitation of use of a body organ or member, or significant limitation of use of a body function or system; or
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> (b) 90 days mobility on the part of the victim (during the 180 days following the accident) to perform substantially all of the material acts that constituted his usual pre-accident daily activities.[75]

New York provides no fault benefits to a maximum of $50,000 per victim. The Alliance of American Insurers has estimated a 6% decrease in average loss costs compared to what the situation would have been without a threshold.[76]

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[74] U.S. D.O.T., Compensating Auto Accident Victims...Report (1985), p. 101.

[75] U.S. D.O.T., Compensating Auto Accident Victims...Report (1985), p. 37. The statute sets out the threshold in nine categories. The 90-day disability provision is considered a catch-all to deal with the unusual cases not covered by the eight verbal categories.

[76] U.S. D.O.T., Compensating Auto Accident Victims...Report (1985), p. 37.

Minnesota has a combined monetary and verbal threshold. The monetary threshold was $2,000 until 1978 when it was increased to $4,000. The verbal threshold is "death, permanent disfigurement, or permanent injury". No fault benefits are paid to a maximum of $30,000 per accident victim. The performance of the Minnesota system has been mixed in large part because of the view taken by the courts of "permanent injury". As I understand it, if body function is restricted by as little as 5% and the restriction is found to be permanent, Minnesota courts have held that the permanent injury threshold has been met. As a result, the monetary threshold has become largely irrelevant.[77]

E. COMPREHENSIVE NO FAULT

Another option is to move beyond a no fault plan solely for motor vehicle accident victims and instead provide a more comprehensive no fault plan embracing all accidents. Such a plan may even be extended to cover disability, however caused. A recommendation for a more comprehensive no fault plan along these lines is, strictly speaking, beyond my terms of reference and would in any event require the cooperation of the federal government. Nevertheless, I think it useful to at least identify this alternative and to discuss it briefly in the context of New Zealand, one jurisdiction which has implemented such a plan.[78]

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[77] This information was provided in discussions with Minnesota insurance officials and attorneys.

[78] The New Zealand plan covers accident victims. The father of the New Zealand plan, Owen Woodhouse, proposed a much more ambitious plan for Australia whch would take the

A comprehensive no fault plan may be said to have two distinct advantages over a no fault plan restricted solely to motor vehicle accident victims. The first concerns horizontal equity; the second, coordination of benefits. A no fault automobile insurance plan singles out for favourable treatment a certain class of victim from among the disabled in society generally. The same, of course, may be said for a workers' compensation regime and for that matter Ontario's present add on system of compensating motor vehicle accident victims. It is not always easy to justify or rationalize such unequal treatment. Once reasonably generous benefit levels are set for a particular class of victim, it becomes more difficult to finance an equivalent set of benefits across all of society.[79]

To avoid duplication of benefits, specialized no fault plans must address the often costly problem of coordinating their benefit package with those benefits

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matter beyond personal injury by accident to deal with incapacity arising from sickness and congenital defect as well. See Report of the National Committee of Inquiry, Compensation and Rehabilitation in Australia (1974). The proposal was rejected by the Australian government.

[79]See Sugarman, Serious Tort Law Reform, and Epstein, "Automobile No Fault Plans." See also Franklin, "Replacing the Negligence Lottery: Compensation and Selective Reimbursement," Virg. L. Rev. 53, no. 4 (1967) at p. 777 where the author stated, "I see little reason to single out automobile victims for special treatment. I do not see why, as an initial proposition, today's law should care how a limb was broken, whether by an intentional wrongdoer, a negligent automobile driver, a non-negligent driver, a wall toppled by an earthquake or a fall in the bathtub."

offered by the government's social welfare programs and by private employers' disability plans.[80] Coordination of benefit problems are reduced or eliminated under a comprehensive plan.[81]

The Experience of New Zealand

There is in New Zealand a political and historical tradition of experimental social legislation dating back to the 1890s. For a time New Zealand was known as "the social laboratory of the world".[82] Following the celebrated Woodhouse Royal Commission Report,[83] New Zealand in 1974 abolished the tort action for damages for personal injuries and in its place instituted a publicly

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[80] See Sugarman, Serious Tort Law Reform. See also Ison, "The Politics of Reform in Personal Injury Compensation." Professor Ison has for some time argued for replacing the "fragmented way of categorized systems of disability compensation that now exist" with an advanced system of social insurance together with the retention of voluntary life insurance. The New Zealand plan is along the lines of reform he has urged. Professor Ison's version of a comprehensive compensation plan for Canada can be found in "Tort Liability and Social Insurance," U. of T. L.J. 19, no. 4 (1969): 614.

[81] Another issue that is central to compensation plans is funding. There is a debate in the academic literature as to whether general (or even specific) compensation plans should be funded on a basis that internalizes accident costs. See generally Sugarman, "Doing Away With Tort Law" at pp. 636-641.

[82] See R.I. Barker, Accident Compensation - An Antipodean Experiment (1987) (unpublished).

[83] New Zealand. Royal Commission to Inquire into and Report upon Workers' Compensation, Compensation for Personal Injury in New Zealand (1967). Owen Woodhouse, a judge of the New Zealand Court of Appeal, chaired the Royal Commission.

delivered comprehensive no fault system of compensation, not only for motor vehicle and workplace accidents, but for all "personal injury by accident".[84] The New Zealand plan is administered by the state-run Accident Compensation Corporation (the "ACC"). The plan is unique in the common law world. Other jurisdictions have schemes for workers or for motorists. None has a compensation system so comprehensive in scope.

The emphasis of the New Zealand scheme is on the community's responsibility to compensate the disabled person and the latter's right to receive such compensation without regard to fault.[85] As stated in the Woodhouse Report:

> The nation has not merely a clear duty, but also a vested interest in urging forward the physical and economic rehabilitation of every adult citizen whose activities bear upon the general welfare.[86]

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[84] Accident Compensation Act, 1972; see Statutes of New Zealand, 1975, Vol. 2, p. 1409.

[85] The five founding principles of the New Zealand plan are said to be (i) community responsibility; (ii) comprehensive entitlement; (iii) complete rehabilitation; (iv) real compensation; and (v) administrative efficiency. See New Zealand. Officials Committee, Review By Officials Committee of the Accident Compensation Scheme (1986). [Henceforth: Officials Committee Review (1986)].

[86] See L. Klar, "New Zealand's Accident Compensation Scheme." An excellent history of the New Zealand scheme is found in Palmer, Compensation for Incapacity (1979). Palmer concedes that Woodhouse's assessment of the common law was not balanced. He views this as strategic. If the common law remained in any form in New Zealand a comprehensive system of reform was financially unattainable. Palmer also observes that the argument against the common law contained in the Royal Commission Report was largely based on principle. There were almost

The focal point of the scheme is earnings-related compensation (ERC). The plan is intended to replace financial loss rather than to use a social welfare philosophy of assuring a minimally adequate living standard. During the first week of disability, the employer pays 80% of income loss. After the first week, the ACC pays 80% of pre-accident earnings to all earners, subject to an upper maximum which is said to cover approximately 97% of New Zealand incomes. It was fundamental to the Woodhouse recommendation that lump sum payments for non-economic loss (save for minor permanent injuries) should form no part of the scheme.[87] Nevertheless, the 1972 Act provided for modest lump sum payments for non-economic loss for:

(a) permanent loss or impairment of bodily functions to a maximum (as of 1982) of $17,000, measured by reference to a schedule of injuries on the workers' compensation model; and

(b) loss of "amenities or capacity for enjoying life including loss or disfigurement" and for "pain and suffering including nervous shock and neurosis" to a maximum (as of 1982) of $10,000 on the basis of an individual assessment and conceived as a supplement to periodic payments for economic loss.

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no empirical data in New Zealand on who got what, when and how from the common law system. Only modest amounts of information were collected by the Royal Commission itself. See Palmer, Chap. 3.

[87] See Palmer, p. 223.

In the case of fatal accidents, both ERC and moderate lump sum death benefits are payable to dependants. Payments continue as long as the condition of dependency lasts or until age 65. The ACC also provides virtually all medical, rehabilitation and funeral expenses.[88]

The inclusion of lump sum payments for non-economic loss represented a political and, as it has turned out, an expensive compromise. Lump sum payments have resulted in an added cost to the system, and an administrative burden.[89]

The 1972 Act provided coverage for non-earners injured in motor accidents only. The coverage extended to medical and rehabilitation assistance and lump sum payments, but not notional income. In 1973 the New Zealand government extended all the provisions of the Act to non-earners except notional income replacement.[90] Using the language of the Ontario automobile insurance policy, there are no income replacement benefits for the deemed to be employed.

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[88] See L. Klar, A Commentary on the New Zealand Accident Compensation Scheme (1986); see also P.H. Osborne, A Critical Evaluation of Liability Insurance, Paper for Ontario Task Force on Insurance (1986).

[89] See Fleming, The Law of Torts. - 6th ed., p. 375; Woodhouse, "Aspects of the Accident Compensation Scheme," N.Z.L.J. no. 18 (October 2, 1979): 395. Woodhouse also criticizes the lump sum payments as a disincentive to rehabilitation.

[90] See Palmer, pp. 222-223.

Under the New Zealand scheme prior to 1982, the funding of compensation for motor vehicle accident victims came from two sources. If the victim was an earner and was injured in the course of employment, compensation was paid out of a fund financed by a levy on employers and self-employed. For all other motor vehicle accident victims, the money came from the motor vehicle fund paid for by owners largely as part of their annual registration fee and, to a small extent, as part of their licence fee. The pre-1982 funding system meant that part of the accident costs of motoring were externalized. In 1982, the funding basis was changed so that all motor vehicle accident injuries were compensated from the motor vehicle fund.[91]

Although there is statutory authority in New Zealand for motorists to be rated according to accident experience, this has not been done. According to one study, neither the introduction of no fault nor the lack of experience rating has caused an increase in accident rates.[92] There is no doubt, however, that under flat

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[91]See C. Brown, "Deterrence in Tort and No-Fault: The New Zealand Experience," Calif. L. Rev. 73, no. 3 (1985): 976. One result of the change was a 50% increase in the levy rates in 1984. The 1982 amendments also allowed the ACC to operate either a fully funded or pay-as-you-go scheme; or a system incorporating both approaches. Until 1982, the ACC operated an ostensibly fully funded system. See Officials Committee Review (1986), pp. 86-89.

[92]C. Brown, esp. at pp. 1001-2. According to Professor Brown the available statistics showed no significant increase in motoring activity and no noticeable increase in accident rates following the introduction of the New Zealand plan. In fact, the downward trend in the number of accidents, deaths and injuries that had started prior to 1974 continued and even accelerated after New Zealand adopted the Accident Compensation Act. Brown has noted

premium rating low risk drivers will subsidize high risk drivers.

Under New Zealand's Accident Compensation Act, there is a four-tiered system of dispute resolution in the event a claimant is dissatisfied with an award. The first level is an informal re-examination by the ACC; the second level is a formal hearing by a review officer of the ACC; there is then a further right of appeal to the ACC itself; and, finally, an appeal to the court. The most common issue reviewed at all levels is the entitlement to and quantum of lump sum compensation for non-pecuniary loss.[93]

It would appear that, in several respects, the New Zealand scheme has worked well. The ERC is quite generous; according to one authority, claims are processed relatively quickly and administrative costs have been kept relatively low.[94]

In other respects the system has apparently not worked as well. It is generally thought that the system has not

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that other factors such as compulsory seat belt laws, stricter drunk driving laws and enforcement measures, the energy crisis and recession, have made an assessment of the New Zealand accident rate somewhat uncertain.

[93]Osborne, at pp. 35-42.

[94]Osborne, pp. 40-41. See also Klar, Speech to Advocates' Society (1986). There is general agreement that the New Zealand plan has not been effective in accident prevention. The system of penalties in the legislation has never been used. The system of rewards last used in 1984/85 amounted to less than 1% of the total levies collected. Even Professor T.G. Ison, a leading advocate of comprehensive no fault, has been critical of New Zealand's accident prevention efforts.

performed to its potential in either the area of rehabilitation or accident prevention. These two activities have been under-funded with the result that advantage has not been taken of the opportunity for coordinated effort that the system offers. Further, in some cases, an adversarial relationship has developed between the victim and the ACC. This is exacerbated by government pressure to control costs.[95]

In 1985, a Committee of Officials was established to review the operations of the New Zealand scheme. The Committee reported in August 1986. Among its principal conclusions was that the financial viability of the current scheme was open to question given the massive cost increases in compensation, leading to a much more rapid rundown in reserves than originally forecast. In the words of the Committee's Report "the committee is firmly of the opinion that the scheme cannot continue in its present form". It recommended the abolition of lump sum payments and was in favour of excluding those with minor injuries from the system.[96]

Another problem which has surfaced has its origins in the design of the original system. The scheme began with a built-in inequity. It applied to accident victims but not to victims of illness or congenital defects. Many in New Zealand contend that if compensation is the dominant

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[95] Osborne, at pp. 39-40.

[96] Officials Committee Review (1986), Klar, A Commentary on the New Zealand Accident Compensation Scheme (1986).

purpose of the scheme there is no reason in principle to single out accident victims.[97]

Quite apart from the equity issue, administering an accident compensation scheme often requires drawing difficult distinctions between "accident" and "disability".[98] Woodhouse, the architect of the scheme, had wanted a plan universally applicable to all disabled, but the New Zealand government concluded such a plan was not affordable. Now the disparity in the treatment of victims of accidents and victims of illness has become quite marked.[99] The Officials Committee considered whether to extend the scheme in its present form to cover

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[97]The Ontario Task Force on Insurance recognized this in its medium and long-term recommendations. Its medium-term recommendation was for a universal accident compensation plan; its long-term recommendation, which it indicated was "...logically compelling" but realistically unattainable in the short to medium term, was for a universal disability compensation program. The Task Force recognized that "universal disability may have to await a much wealthier economic base for its implementation and also a complicated process of rationalization between federal and provincial authorities and private insurers..." See Ontario Task Force on Insurance, A Pre-Publication of the Final Report (1986), Vol. I, pp. 104-5.

[98]See Sugarman, "Doing Away With Tort Law."

[99]New Zealand does have social welfare provisions for victims of disease, but they are less generous. Professor Ison found that victims of disease in New Zealand at times feel demoralized because they are treated worse than accident victims with whom they often come in contact in hospitals and rehabilitation centres. See T.G. Ison Accident Compensation: A Commentary on the New Zealand Scheme (1980), p. 22.

all disabled, but concluded it was not a feasible option because of cost.[100]

The Committee also considered the no fault concept itself, although this was for practical purposes beyond its mandate.[101] The Committee questioned "...to what extent it is still relevant that many accidents are suffered through specific wrongdoing of other individuals". The Committee further recognized that the notion of "justice to the victim" was still important as a basis of policy in New Zealand. To the extent that this reflects a concern about treating innocent victims and wrongdoers in the same way, it does not appear that there has been any response within the plan.[102]

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[100]The Officials Committee Review indicates that the disparity reflects different historical developments and philosophies. Accident compensation had its origins in common law damages for personal injury and in worker compensation legislation. By contrast the philosophy underlying sickness benefits was that of universality based on need and funded from general taxation.

[101]The Committee's mandate was to accept the five founding principles of the plan which embraced the no fault concept.

[102]Officials Committee Review. Concern over fault and fairness are evident within the system. Two examples will suffice. First the New Zealand Court of Appeal has held that an action for exemplary damages may be maintained by a victim against an injurer where the latter inflicted intentional harm on the former. See Donselaar v. Donselaar, [1982] N.Z.L.R. 97; second, many New Zealanders were offended when a man convicted of the murders of two women and serving a life sentence was compensated by the ACC for injuries suffered in an attempted escape from prison. See Klar's Speech to the Advocates' Society, pp. 9-10. Another issue is whether a universal compensation scheme should pay for an individual who chooses to engage in reckless activities. See Trebilcock, Where Do The Bucks Stop?

One concluding observation on the New Zealand plan is that it must be viewed in its social and cultural context. New Zealand has long been a relatively socialistic country with broad social insurance programs already in place. Like Sweden, New Zealand has a small relatively homogeneous population, perhaps more receptive than other countries to re-distribution of income plans. Even New Zealand's neighbour, Australia, has rejected a New Zealand-like plan which was drafted by a team that included, at the invitation of the Australian Government, the drafters of the New Zealand law. Further, in Great Britain, a royal commission headed by Lord Pearson, after an extensive inquiry, rejected the New Zealand approach.[103]

F. OTHER COMPENSATION PROPOSALS

There have been countless proposals to change our way of compensating accident victims. I obviously cannot discuss them all. I propose to refer briefly to the writings of Professors O'Connell and Sugarman in the United States and Professor Ison in Ontario. Their proposals are, although different, representative of the main directions of change proposed in the last quarter century.

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[103] Palmer, Compensation for Incapacity; Fleming, The Law of Torts. - 6th ed., pp. 376-7. The proposed Australian plan went beyond the New Zealand system in seeking to include those disabled by illness and congenital defects. The Australian proposals were opposed by the insurers, the lawyers, the trade unions and four of the six state governments. See Palmer, p. 174.

Without doubt, the leading American proponent of no fault in the last 20 years has been Jeffrey O'Connell, now professor of law at the University of Virginia. The landmark text Basic Protection for the Traffic Victim, co-authored by Robert Keeton and O'Connell and published in 1965, became a catalyst for the various threshold no fault schemes enacted in several American states in the early 1970s.

O'Connell has advanced a number of quite different no fault proposals over the past two decades. In what follows, I summarize some of his main proposals.

In Basic Protection for the Traffic Victim, Keeton and O'Connell embraced what was essentially a monetary threshold scheme. The principal features of the Keeton/O'Connell proposed Motor Vehicle Basic Protection Insurance Act were as follows:[104]

(a) If tort damages for pain and suffering did not exceed $5,000 and other tort damages principally for economic losses did not exceed $10,000, first party basic protection benefits were to replace any tort action. In cases of more severe injury, the tort action was preserved but the recovery was reduced by these same amounts.

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[104] For details of the model statute see Basic Protection for the Traffic Victim. At the time of the writing of this book, Keeton was a Harvard law professor. He is now a judge.

(b) Basic protection benefits were to be paid on a first party basis without regard to fault.

(c) Basic protection benefits were to be limited to economic loss and included net income loss and reasonable expenses incurred. The benefits were to be extended to survivors.

(d) Insureds could purchase optional added protection coverage for non-pecuniary (pain and suffering) loss and insurers were authorized though not generally required to provide such coverage.

(e) Property damage was excluded from the basic protection plan.

In The Lawsuit Lottery published in 1979, Professor O'Connell recommended a scheme of elective first party no fault insurance for all accidents.[105] The proposed scheme would work as follows: an insurance company would offer its insureds no fault economic loss coverage in increments of $10,000 up to any amount. Nothing would be paid for non-economic loss, nor would payment be made for losses already recovered from another source. In return for this guarantee of no fault benefits, the insured would transfer to his insurance company his entire fault-based claim against any at-fault third parties. The insurance company would agree to pay the insured for his economic losses in excess of his no fault coverage out of whatever amount the company could recover in a third party claim.

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[105] In 1975, Professor O'Connell proposed third party elective no fault insurance.

The transfer of the fault-finding claim to the no fault insurance carrier would have to be made at the time the no fault coverage was obtained, that is, prior to any injury to the insured. While the plan was elective, Professor O'Connell suggested that there was a strong public preference for the certainty of payment for out-of-pocket losses caused by an accident over a "gamble" for payment of economic and non-economic losses.

In the last few years, Professor O'Connell has expanded his concept of giving accident victims a choice between securing compensation for economic losses and medical expenses on a no fault basis and waiving their rights to tort claims or instead waiving these no fault benefits and pursuing a law suit for the full tort measure of damages.[106] In the motor vehicle accident context, Professor O'Connell observes that motorists today do not have a choice between fault and no fault insurance. The motorist in a tort state cannot purchase no fault insurance. The motorist in a threshold state cannot reject no fault benefits or law suit restrictions in favour of traditional insurance.[107] And the motorists in

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[106]See e.g., J. O'Connell, 'A "Neo No Fault" Contract in Lieu of Tort: Pre-accident Guarantees of Post-accident Settlement Offers,' Calif. L. Rev. 73, no. 3 (1985): 898; J. O'Connell and B. Kelly, The Blame Game (1987); O'Connell and Joost, "Giving Motorists a Choice Between Fault and No-Fault Insurance," Virg. L. Rev. 72 (1986): 61.

[107]Other than Kentucky.

a tort add on system cannot opt for restrictions on law suits.[108]

O'Connell's most recent proposal advanced in 1986 is to give drivers a choice between purchasing first party no fault insurance and third party liability insurance. If two drivers, each with first party no fault insurance, are in an accident, then each looks to his own insurer to cover his losses. If two drivers with third party coverage are in an accident, recovery would be governed by tort law and third party insurance coverage. The more difficult situation is a collision between two drivers, one with no fault coverage and the other with third party liability coverage. In that situation, the driver with no fault coverage would recover under his no fault policy from his own insurer and would not, even if negligent, be liable for the other driver's losses. In order to permit the driver with third party coverage to recover his tort compensation, O'Connell proposes a compulsory automobile insurance "connector" in the form of modified uninsured motorist coverage. The driver with third party coverage and the "connector" would then look to his own insurer for tort damages if negligence on the part of the other driver could be proved.[109]

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[108]O'Connell and Joost, at pp. 62-63. The choice O'Connell offers is between tort and no fault. He does not consider a system such as Ontario's which combines tort recovery with no fault benefits.

[109]O'Connell and Joost, pp. 77-82.

As Professor Trebilcock noted,[110] Professor O'Connell has likely advanced his elective scheme at least in part out of recognition of the political resistance to further enactment of threshold or pure no fault schemes. O'Connell undoubtedly believes that, given a choice, most motorists will prefer the no fault option. However, he seems prepared to recognize that not all motorists may do so.[111] In doing so, he seems to recognize that the tort system, with all its imperfections, may be difficult to dislodge.

In a series of recent articles, Professor Stephen Sugarman, a law professor at the University of California, presented a new proposal for injury compensation which he considers to be a "substantial first step" in the direction of providing most of the population with reasonable first party income protection and medical benefits.[112] My staff and I had the opportunity to discuss this proposal with Professor Sugarman when he attended a tort/no fault discussion group convened by the Inquiry in Toronto on May 15, 1987.[113]

Sugarman rejects the tort system as "an intolerably expensive and unfair system of compensating victims". He also rejects no fault accident compensation plans,

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[110] Trebilcock, Where Do the Bucks Stop?, at pp. 22-23.

[111] O'Connell and Joost, pp. 82-83.

[112] See Sugarman, "Doing Away with Tort Law"; Sugarman, Serious Tort Law Reform (1987) (unpublished).

[113] See Chapter 3.

directed to particular groups, first because they give preferential treatment to one class of victim among society's disabled and, second, because specialized no fault plans are inefficient in dealing with collateral source payments and in avoiding duplication of benefits.

Sugarman makes particular reference to automobile no fault plans. While arguing these plans are an improvement over the tort system, he suggests that if these plans pay only for otherwise uncompensated losses, then they are not a very good purchase for people with other sources of protection;[114] whereas if automobile no fault benefits are primary, then complicated reimbursement arrangements with employee and other benefit plans must be established.

This reasoning leads to the basic direction of Professor Sugarman's reform proposal: rather than layering in another new scheme of benefits, he argues for improving the existing mechanisms for income and medical expense protection. Sugarman's basic proposal involves distinguishing between short-term and long-term disabilities. He would improve the existing employee benefit and social insurance system for persons disabled for whatever reason for less than six months, and for persons who are disabled longer, for their first six months of disability. Access to the tort system would be restricted to those suffering a serious disfigurement or

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[114] In light of this consideration, Epstein suggests that the real benefit that accrues from losing the right to be a tort plaintiff is the elimination of the risk of being a tort defendant. See Epstein, "Automobile No Fault Plans: A Second Look at First Principles."

impairment or to those who had injuries causing more than six months of disability.

The central details of Professor Sugarman's reforms are as follows:[115]

(i) A generous temporary disability insurance program (TDI) for short-term income replacement. The TDI plan would provide benefits on an after-tax basis equal to 85% of the employee's pre-disability earnings. The maximum earning level to which the TDI would be applicable would be twice the average weekly wage. Non-earners disabled for six months or less would not benefit from the program. The TDI program would cover work as well as non-work disabilities and there would be a seven-day waiting period. The TDI payments would be funded by employer and employee contributions.

(ii) Employers would be required to provide their employees with paid sick leave benefits according to a reasonable schedule which would take care of the first week's disability.

(iii) Unlimited medical health care and rehabilitation benefits would be provided.

(iv) Tort victims would not be able to sue for the first six months of lost income. Any short-term income loss not replaced by mandatory sick leave

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[115] They are set out in his article on Serious Tort Law Reform.

and TDI plans would have to be borne by victims who would of course be free to make their own private arrangements for additional protection.

(v) There would be a threshold for access to the tort system for non-pecuniary loss which would require more than six months' disability or serious disfigurement or impairment. Sugarman attempts to make a principled case for a threshold; what he seeks to remove from the tort system is transitory pain and suffering and what he seeks to preserve are those cases in which there have been serious consequences to the victim's body. His proposal (based on Michigan estimates) is intended to eliminate law suits for non-pecuniary loss in at least 90% of the cases.

(vi) A cap on general damages of $150,000 indexed every five years for inflation.

(vii) The abolition of the collateral source rule.

(viii) The abolition of the contributory negligence rule.

The essence of Sugarman's proposal is a comprehensive disability plan with total coordination of all existing benefits (including government benefits) and threshold access to the tort system for more serious injuries. Sugarman is opposed to specialized no fault compensation plans. In this he is not alone. There are other academic writers who favour comprehensive disability plans but who would go farther than Sugarman and would eliminate all access to the tort system. In Ontario they include

Professor Ison who has written a number of thoughtful books and articles supporting comprehensive compensation. Professor Ison, who has an intimate knowledge of the New Zealand compensation plan, favours a similarly structured plan but extended to all who are disabled. I think Professor Ison is correct in concluding that such a plan cannot be delivered by the private sector but has to be delivered publicly. The adoption of such a plan in Canada would require complete federal/provincial cooperation.

One of the most forceful criticisms levelled at the existing tort system relates to the less serious injuries, the minor claims. Costs associated with investigating and defending these claims are out of proportion to the modest worth of the claims themselves. In the result, insurers often offer to settle these claims for more than their probable trial assessment value. This is essentially a business decision which all too often results in a $500 claim being settled for $1,500. Application of the collateral source rule extends the overcompensation in those cases where collateral source payments are available to the plaintiff.

One proposal to address this problem which was put forward by several persons with whom I spoke involves deducting a flat amount from the non-pecuniary damage portion of the tort claim. If, for example, the deductible was $5,000, then any award for pain and suffering would automatically be reduced by that figure. If the award, but for the deductible, would have been $20,000, then the actual award would be $15,000. If the award, but for the deductible, would have been $3,000, then the victim would not receive anything for non-economic loss. An exception could be made on grounds of

social policy so that the deductible would not apply to awards for the catastrophically injured.

The practical effect of this deductible (assuming reasonable no fault benefits) would be to exclude minor injury claims worth $5,000 or less from the tort system.[116] The deductible would operate as a threshold. Proponents of this proposal state that it has the advantage of certainty and is less capable of abuse than the monetary thresholds favoured by American jurisdictions.

Finally, I have considered the general structure of insurance compensation plans used in Great Britain, West Germany, Switzerland, France, Sweden, Denmark and Israel. Some I have regarded as unworkable in Ontario; others as too costly. For example, in Great Britain and in Switzerland, automobile accident compensation is paid only through the tort system. There is no evidence of any serious inclination in either jurisdiction to change the system. For reasons more fully developed in Chapter 12, I do not think it is appropriate to resort only to tort law to compensate motor vehicle accident victims. I regard the Swedish system as too costly; and I do not regard the West German combination of absolute and negligence-based liability as representing an improvement to Ontario's current system.

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[116] It would likely also exclude many claims just above $5,000 because claimants would be unlikely to assert them given the small amounts at stake.

CHAPTER 12

RECOMMENDED SYSTEM OF COMPENSATION

A. INTRODUCTION

All submissions have been considered, public hearings have been held, the relevant literature has been read and the research is complete. I now, therefore, turn to consider how those injured in motor vehicle accidents in Ontario should be compensated.

As I stated in Chapter 2, I regard the interests of those who suffer injury and loss as a result of motor vehicle accidents and the interests of Ontario's drivers required by law to purchase automobile insurance, to be of primary concern.

Premiums, bodily injury loss costs, transaction costs, the tort system, no fault, threshold no fault, public insurance, gross-up, prejudgment interest, the Family Law Act, collateral source payments -- the list goes on -- obviously raise important issues; but in the final analysis value judgments have to be made. They have been, and they are mine.

There are those who approach the "tort system"/no fault debate (to say nothing of the private sector/public insurance debate) as an article of faith. Others would limit the perimeters of the debate to a study of economic efficiency. Some have suggested systemic changes should only be recommended upon acceptance of convincing evidence that some other system is clearly superior to our present system. Still others reject our present system

out of hand because of the inefficiencies of the tort system. If common ground can be found, it is located in the pervading recognition that first party no fault accident benefits should be increased.

Although not necessary, it is at least interesting to identify the no fault debate's major players. Not all, but a majority of the automobile insurance industry favours some form of no fault compensation scheme. The I.B.C.'s highly visible proposal urges what is referred to in Chapter 11 as "threshold no fault". It has become reasonably clear to me that the unstated preference of a number of insurers is for pure no fault rather than threshold no fault. Some insurers, clearly a minority, prefer our present system, with increased no fault benefits.

Academic opinion clearly favours no fault compensation. At least on this issue, academics cannot be accused of talking only to themselves.[1] I think I am on safe ground in stating that the preference of a majority of academics is for a comprehensive disability compensation plan.[2] Some academics nevertheless recognize that this goal may be impractical, given political

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[1] See, for example, Globe & Mail (March 20, 1987) where Professor Hutchinson's comment "Lawyers' Concern is Really for Profit", and Professor Steven Wexler's comment "Pros and Cons of Fault and No-Fault" consume an entire page.

[2] See generally T. G. Ison; Alan Hutchinson, "Beyond No-fault," Calif. L. Rev. 73, no. 3 (1985): 755; See also Deborah Coyne, "Compensation Without Litigation," Policy Options April 1987):3.

realities such as major federal/provincial jurisdictional conflicts and funding.[3]

Lawyers' groups and others emphasize individual responsibility, fairness, the tort law's capacity to deter and to provide individualized compensation; they urge resistance to anything that will in any way erode those values and rights.[4]

Both the Bar and the insurance industry can properly be accused of being stakeholders; both have an obvious vested interest in the final disposition of what Ontario's motor vehicle accident compensation system is to be. I do not regard that as a basis upon which to ignore the views of either. Both have a capacity to provide insight into the practical consequences of suggested changes. The existence of vested interest should affect the weight of the evidence, not its admissibility.

Academic interest in the tort system and in compensation of the injured has been intense. The criticism that academics have often ignored practical matters such as cost is, in my view, valid; once again that should be a matter of weight not admissibility.

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[3] Professor Craig Brown articulately set out this position at a Toronto Conference, Tort Law in Crisis, February, 1987. Professor Brown was instrumental in preparing the I.B.C.'s submission to this Inquiry.

[4] The Bar was officially represented by the Canadian Bar Association and the Advocates' Society and unofficially by FAIR (Fair Action in Insurance Reform).

Through the canyon separating those who favour the demolition of the tort system and those who favour its renovation drive most of Ontario's insured motorists, largely unaware of what the tort system is, and what no fault insurance means. I think it is because of this general lack of public awareness that the no fault/tort law debate has not been a significant concern to consumers. The destiny of the tort system has elicited letters to the editor, but not self-immolation. Ontario's drivers, those most affected by the no fault debate, have not been major participants in it. The relative neutrality of most of the driving public has tended to emphasize (and perhaps overemphasize) the specific views of the insurance industry, academics, and the Bar.

Before turning to the criteria by which any motor vehicle accident compensation plan should be evaluated, I want to set out what I mean by no fault and threshold no fault. In the motor vehicle accident context, a no fault form of compensation plan is a plan in which an injured person's entitlement to compensation is neither reduced, nor affected, by that person's driving conduct. In a pure no fault compensation environment, a person injured in a motor vehicle accident will be paid the plan's stipulated benefits without regard to driving conduct, and will have no independent right to sue for damages based on fault.

Threshold no fault pays prescribed compensation without regard to fault, but permits an injured person to seek compensation through the tort system for pain, suffering and loss of enjoyment of life (non-pecuniary general damages), if the injuries, or in some cases,

injury-related expenses, pass a pre-determined threshold.[5] The idea is to pay basic no fault compensation to all those injured in motor vehicle accidents without regard to driving conduct, i.e., fault, and to permit claimants in more serious cases to resort to tort law and the courts for compensation for non-pecuniary general damages.

No fault plans often contain exclusions which eliminate or reduce an insured's entitlement to benefits. Some exclusions are related to driver conduct (e.g., impaired driving). This is for the most part a social policy matter. Such exclusions dilute the extent to which compensation plans containing them can truly be viewed as no fault plans.

Having dealt generally with what no fault is, let me briefly set out what it is not. There is no conceptual relationship between no fault insurance and government insurance. That point must be emphasized because it has become increasingly obvious to me that no fault insurance is equated with government insurance, and government insurance with no fault insurance. Many seem to think that Manitoba, Saskatchewan and British Columbia (all of which have government-delivered automobile insurance) have no fault insurance plans. None of those provinces, in fact, has a no fault insurance plan, any more than Ontario, which delivers insurance through the private sector, has no fault insurance. The three western provinces may be contrasted with Quebec which has both no fault automobile insurance and government insurance.

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[5] Depending on design, a threshold no fault plan may provide access to the tort system for excess economic loss.

Ontario, Manitoba, Saskatchewan and British Columbia have structurally similar automobile insurance/ compensation plans. No fault benefit levels differ, but not to any great degree. In all four provinces and in Alberta, Nova Scotia, New Brunswick, Prince Edward Island and Newfoundland, an injured person may seek damages from a third party based on that third party's alleged fault. There is no restriction in access to tort law for compensation in any Canadian province, except Quebec, where the restriction is complete. In all Canadian provinces save Quebec (including, I emphasize, Manitoba, Saskatchewan and British Columbia), a recovery effected through resort to tort law is reduced by the no fault benefits paid to the claimant.[6]

Before I deal with evaluation criteria and competing compensation systems, I should make some general reference to what ails our present insurance/compensation system.

B. THE PROBLEMS

It seems to me to be sensible to turn briefly to the important, but little understood, issue of why there are difficulties with automobile insurance and in some respects with our compensation system. That can only be accomplished by identifying the problems.

The Ontario Task Force on Insurance concluded that the massive problems in liability insurance were not found

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[6] In Ontario, the reduction is not only for no fault benefits paid, but no fault benefits which are available. See Stante v. Boudreau.

in automobile insurance.[7] This conclusion is correct. Nothing close to a causal link between the liability insurance crisis and existing problems in automobile insurance was established by the Ontario Task Force on Insurance.

The Task Force Report did refer to the increase in the average number of bodily injury claims per insured car and the increase in the average cost of bodily injury claims. In dealing with increased bodily injury claims costs, the Task Force Report stated:

> ...this steady upward drift must be addressed now. It reflects dissatisfaction with the accident benefit program, which is contributing to increased use of the expensive tort/litigation system. The cost of the system is increasing, a trend that may soon press against the limits of affordability and acceptability.[8]

Although the Task Force Report identified both the increasing number and the increasing cost of bodily injury claims as problems, it is clear that the Report viewed the steady increase in average bodily injury claims costs as the primary problem. The Task Force was also concerned about transaction costs and particularly defense legal costs.[9] The average cost of a bodily injury claim includes the claim and claims adjustment expense; claims adjustment expense includes defense legal costs. Double counting should be avoided, if not in the interest of rhetoric, at least in the interest of accuracy.

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[7]Ontario Task Force on Insurance, Final Report (1986), p. 21.

[8]Ontario Task Force on Insurance, Final Report (1988), p. 73.

[9]Ontario Task Force on Insurance, Final Report (1986), p 30.

There are other problem areas. At the premium level, there is the issue of affordability. Premium levels have increased dramatically over the past two years. Automobile insurance is compulsory and is theoretically available to all through either the regular or the residual markets. Nevertheless, for some, affordable insurance is not available. In making that statement, I think of some young drivers, taxi operators and those that for sometimes inexplicable reasons are unable to secure automobile insurance through the regular market. While the availability of insurance through the residual market is secure, there is such a substantial difference between average weighted regular market premiums and residual market (Facility Association) premiums, that questions of affordability and fairness arise, particularly for those drivers who should be insured in the regular market.

I approach the affordability issue somewhat cautiously. I take it no further than to state that because automobile insurance is compulsory, it must be made available at a price consistent with sound insurance principles. I do not think it is appropriate to impose an obligation on the government or on the private sector to make automobile insurance affordable to all, particularly those drivers who by their conduct deserve to pay high premiums. Automobile insurance is compulsory, driving is not.

There is a pervading concern about the fairness of premium differentials; these differentials occur as a result of the application of the classification system and individual insurers' underwriting policies. For example, some suggest premiums for young male drivers and taxis are unfairly high, even if premium levels for each are

statistically justified. Others suggest those premiums are too high and are not statistically justified. That problem was discussed in some respects in Chapter 6, and will be further discussed in Chapter 15. For now, I note that given a reasonable classification system, it is difficult, and close to impossible, for the private sector to permit premium levels for established cells within the classification system to fall below levels which are actuarially sound. I emphasize that point because of repeated statements by some that premium levels for certain identified driver groups are unduly burdensome, notwithstanding the fact that those premium levels may be perfectly sound when assessed on an actuarial basis.

As has been stated earlier, another problem area is marketing; the consumer should have better access to information and, hence, enhanced capacity to choose. From the consumer's standpoint, the intensity of competition within the private sector has been dulled by the manner in which automobile insurance is marketed. From the insurer's standpoint, business acquisition costs (eg., brokers commissions) in the private sector are high. I view this as a problem area as well.

There is also the very serious problem of the delivery of benefits, particularly at the first party level. That problem has been discussed in Chapter 5.

These are, of course, compensation problems. They include cost, uncertainty, delay and the uncompensated. Most, if not all, of these compensation-related problem areas are reflected in criticisms of the tort system.

Finally, I think it must be said that although there are a number of problem areas, neither the automobile insurance system nor the compensation system is crumbling. The patient may not be entirely well; vital signs, however, are intact.

C. EVALUATION CRITERIA

Before dealing with competing compensation systems, it is necessary to identify the criteria against which I think those systems should be assessed. I consider the following to be reasonable evaluation criteria.

(a) Compensation

Compensation is the essence of my undertaking as the name given to this Inquiry implies. I include within this evaluation criterion the issues of eligibility and quantum, that is, who will be compensated by the system and in what amount. This exercise will identify those who may be undercompensated within any compensation system. I also take into account the timeliness and certainty of the payment of compensation, particularly for economic loss.

(b) Rehabilitation

Any reasonable compensation scheme should be structured to enhance rehabilitation in three general ways. Rehabilitation must be reasonably funded; funds must be made available so that rehabilitation can commence at an optimal time; and eligibility for payments must continue over a sufficiently long time period to permit the effective rehabilitation of the insured.

(c) Cost Efficiency

The public is legitimately concerned about the quantum of automobile insurance premiums and is entitled to know the general cost implications of alternative compensation systems. The cost efficiency of any system is something which must be taken into account, (and I cannot resist noting almost never is), when compensation/insurance issues are debated.

(d) Incentives/Deterrence

A compensation system should provide incentives for appropriate driving behaviour and deter unacceptable driving behaviour. Deterrence-related gains or losses which may result from the implementation of any particular system of motor vehicle accident compensation should be taken into account.

(e) Fairness

It is important that the conceptual underpinnings of any compensation plan take into account basic notions of fairness and justice.

(f) Insurance Considerations

The design of any workable compensation plan must have regard to the fact that benefits will be paid through first or third party insurance, delivered either by the private sector or by a public monopoly.

(g) Constitutionality

Any compensation scheme must be lawful. A number of relevant constitutional issues will be discussed in Chapter 14.

D. ASSESSMENT OF THE ALTERNATIVES

In assessing the alternatives, I should state at the outset that I have not considered comprehensive compensation plans as a viable option. The scope of this Inquiry is restricted to motor vehicle accident compensation. I have no mandate to design a comprehensive compensation package however rational it may be; nevertheless, I think that the design of a compensation scheme for motor vehicle accidents should take into account the prospect of the eventual development of a comprehensive compensation scheme. Benefits in the motor vehicle accident compensation scheme at the first party level should not be set so high as to preclude the eventual integration of that scheme into a more comprehensive compensation package.

We are probably political light years away from adopting a comprehensive accident or disability compensation plan. It seems to me to be necessary that any changes in the motor vehicle accident compensation system be capable of almost immediate implementation. While I endorse an assessment of a comprehensive compensation plan, it is not a workable option given my mandate and the requirement for early implementation. Nevertheless, a comprehensive compensation plan for accidental injuries, or beyond that a universal disability

program should be given further consideration at the federal and provincial levels.

The workable compensation options are pure no fault, threshold no fault (in its many potential forms) and an add on compensation plan (with co-existing no fault benefits and tort system access).

In a pure no fault system, insureds have no access to compensation beyond that established by the no fault plan.[10] Compensation is provided without regard to fault, although pure no fault and threshold no fault plans may establish exclusions which limit eligibility for no fault benefits. The idea in a pure no fault compensation plan is to compensate all those injured in motor vehicle accidents on the same basis. The emphasis is on economic loss, although pure no fault plans often provide modest non-economic compensation.[11]

Benefit levels in pure no fault and threshold no fault can be set at any level that cost permits. In threshold no fault there is a restricted right to sue, with the result that a threshold no fault system is exposed to costs not encountered in pure no fault. This tends to result in no fault benefits in threshold plans being more modest than in pure no fault plans.

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[10] Some insureds, of course, may have access to collateral source payments.

[11] For example, the motor vehicle accident no fault compensation scheme in Quebec and New Zealand's comprehensive accident compensation scheme both provide for some non-economic loss compensation.

There is no doubt that both pure no fault and threshold no fault plans can be constructed so as to have the capacity to deliver prescribed benefits periodically, as entitlement arises or continues. Tort system delay is avoided. Rehabilitation goals are clearly better served through first party insurance. Nevertheless, it is clear that if premiums are to be controlled, cost efficiencies are crucial to no fault plans. The money has to come from somewhere. If accident victims are to be paid full no fault benefits, transaction costs have to be reduced, and to the extent necessary something has to give on the claims side. That something is compensation for pain, suffering and loss of enjoyment of life (non-pecuniary general damages).

In assessing compensation schemes, cost efficiency considerations are important; however, the efficiencies of any compensation scheme must be looked at on a comparative basis. The comparison must be realistic. No useful purpose is served by comparing no fault's cost effectiveness to the tort system's when it is not proposed to resort to the tort system alone for compensating those injured in motor vehicle accidents.

(a) Compensation

From the standpoint of the compensation criterion, both pure no fault and threshold no fault are superior to the tort system. If a system's objective is to compensate, the tort system does not achieve that objective. Those who defend the tort system argue that it has never purported to compensate all those injured in motor vehicle accidents. While that contention is correct, it misses the point. The crucial issue is what

the system does from a compensation standpoint. Those at fault receive nothing under the tort system. Those partly at fault receive reduced compensation based on the extent of their contributory negligence.

Tort system compensation is often delayed. Delay is the result of the common law's requirement that compensation be paid in a lump sum. There is an uncertainty about lump sum compensation in that predictions must be made about future losses and those predictions may not always be accurate. To the extent that fault is an issue, there may also be uncertainty as to how that issue will be resolved.

Set against the structural weaknesses of the tort system are the main advantages of no fault compensation plans. In no fault, all those injured are entitled to compensation, at least for economic loss, up to some pre-determined limit. There is little or no uncertainty as to a claimant's eligibility for compensation or, in most instances, the quantum of no fault compensation. Benefits are paid quickly, at least in theory.

(b) Rehabilitation

It is clear to me that rehabilitation is an essential objective of any compensation system and that it cannot be realistically achieved through the tort system. The tort system, involving as it does delayed lump sum compensation, provides a disincentive to rehabilitation. Although the same can be said about periodic payments paid on a first party basis, I think the evidence is overwhelming that rehabilitation must be a first party obligation. Because no fault compensation is delivered on

a first party basis and because rehabilitation benefits must be made available without undue delay, the rehabilitation objective is far better served by no fault than tort law. It is in the public interest that all the injured be rehabilitated. The availability of rehabilitation benefits should not be linked to fault. This, however, does not mean that some form of first party no fault rehabilitation benefits cannot co-exist with tort recovery.

(c) Cost Efficiency

Cost efficiency is a major issue in the tort system/no fault debate. Proponents of no fault commonly point to its efficiencies and to the inefficiencies of the tort system. In general terms, this argument is premised on the contention that transaction costs in no fault are less than transaction costs in the tort system. To the extent that this is true, it can be said that a first party no fault insurance compensation plan is more cost efficient than third party tort system compensation.

The usual measurement of efficiency in this area is the percentage of the premium dollar available to claimants in the system; or to put it another way, an assessment of how much of the premium dollar is consumed by expenses.

It must be emphasized that what is actually paid to claimants in any system will depend on the design of the compensation system, accident frequency and accident severity, not expenses. Compensation has to be paid in accordance with the provisions of the compensation system.

This is so however efficient or inefficient the system may be from an expense standpoint.

Furthermore, while we have reasonably solid data as to the tort system transaction costs breakdown, the same evidence is not available on the no fault side. We can at best estimate transaction costs in a pure no fault or threshold no fault plan.

For the purposes of this analysis, an insurer's expenses can be viewed as comprising operating expenses and claims adjustment expenses. That is how insurers characterize expenses. Operating expense includes business acquisition costs (brokers' commissions, etc.), administration expense, salaries, etc. For these purposes, operating expense can also be taken to include 3% of earned premiums all insurers are required to pay in premium tax and the 0.4% of earned premiums insurers pay in licence fees. Claims adjustment expense is regarded as any expense relating to the claims process. The major components of claims adjustment expense are defense legal and adjusters' costs.[12]

I.B.C. data establish that aside from premium tax and licence fees, the insurer's operating expense is approximately 20.9% of earned premium.[13] Claims adjustment expense is approximately 11% of earned premium. This claims adjustment expense estimate is

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[12] Party-and-party costs paid to claimant's counsel are regarded as being part of claims, not claims adjustment expense.

[13] See Inquiry Research Study II. See also Chapter 15, Table 15.2.

consistent with I.B.C. data, the experience of a major insurer,[14] the 1986 Woods Gordon study and the Inquiry Claims Survey. If the 3.4% for premium tax and licence fees is included, expenses total approximately 35.3% of earned premiums. Thus, approximately 64.7% of earned premiums is available to pay claims in our present system.

It does not seem to me that the insurer's operating expense can be significantly reduced by a conversion to a no fault compensation system. There is no reason to conclude that the insurer's administrative infrastructure would shrink if our compensation system were to change as long as insurance is sold on an individual basis.

There could, however, be reductions in claims adjustment expense. In pure no fault, there would be no need to commit resources to fault determination, except for premium rating purposes. Defense legal costs which account for about 75% of claims adjustment expense[15] would be substantially reduced, but would not disappear, in a pure no fault plan. Some of it would be transferred to the first party (no fault) side. The same can be said about adjuster's expense. Even in pure no fault, disputes over entitlement and quantum will arise. The Quebec experience has confirmed this. In some disputed cases, insurers will have to retain counsel. The legitimacy and extent of injuries will have to be investigated. One insurer has estimated, and I tend to agree, that in pure no fault claims adjustment expense can be reduced by no more than 5%, that is from approximately 11% to 6% of

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[14] See The Wellington Insurance Company Submission.

[15] See Inquiry Claims Survey transaction cost breakdown.

earned premium. Assuming that conclusion to be correct, and further assuming that operating expense remains constant, all expenses in a pure no fault plan would approximate 30.3% of earned premium (operating expense 20.9%, premium tax and licence fees 3.4%, claims adjustment expense 6%). That would leave approximately 69.7% of earned premiums available to pay claims.

In threshold no fault, the potential for reduction of claims adjustment expense is minimal. Because serious cases meeting or passing a defined threshold will enter the tort system and because it is the serious cases which attract most of the defense legal expense dollars, it is unlikely that defense legal costs will be significantly reduced in threshold no fault. There will, nevertheless, be some reduction. Adjusters will not have to investigate fault in those cases that obviously will not meet the threshold; but, as is the case in pure no fault, adjusters will still be required to investigate the legitimacy and extent of injuries. At least in those cases falling below the threshold, only the adjuster for the first party insurer will be involved. In cases close to or above the threshold, adjusters for both the first and third party insurers may be involved.

The Ontario Task Force on Insurance briefly compared the tort system and no fault insurance plans on efficiency grounds. The Task Force put it this way:[16]

> Even if all of the other deficiencies described above could be eliminated,

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[16]Ontario Task Force on Insurance, Final Report, (1986), p. 66.

> the final one is the most serious: the inordinate financial cost of continuing to use tort for injury compensation. A large portion of every premium dollar is eaten up by the transactions costs of the tort-insurance system. More than 50 cents of every premium dollar is absorbed in the administrative and legal costs of running the system.
>
> Less than 50 cents of the premium dollar is actually paid out in compensation under tort, compared with 80-90 cents that are paid out under no-tort insurance plans.

The references to the inefficiencies of tort and the efficiencies of no fault referred to above, were included in that part of the Ontario Task Force on Insurance Report dealing with liability insurance and the liability insurance crisis of 1985-1986. When the Task Force dealt with automobile insurance (in Part C of its Report), it provided an expense breakdown which suggests that substantially more than 50¢ of the premium dollar is available to those injured in motor vehicle accidents, if claims adjustment expense is included at approximately 11%. The Task Force breakdown records claims and claims adjustment expense at 64.3% of the automobile insurance premium dollar. If claims adjustment expense (11%) is deducted and profit (2.5%) is ignored, on the Task Force's own data, 55.8% of the premium dollar would be available for claims.[17]

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[17]The Task Force breakdown notionally attributes 2.5% of the premium dollar to profit. Notional profit is not usually included in determining what part of the premium dollar is available to pay claims after all expenses are accounted for.

Although the data establish that more than 50¢ of the premium dollar is available to pay claims, the entire exercise should be approached with caution for a number of reasons. First, claims are a primary, not secondary obligation. If expenses are high, it does not follow that claims are low. Nor can it be said that if expenses are low, claims will be high. Investment income is completely ignored in those studies attempting to determine what part of the premium dollar is available to pay claims. In normal circumstances, in a competitive market, claims and all expenses may well exceed earned premiums. Second, the data referred to by the Ontario Task Force on Insurance in its analysis of the components of the automobile insurance premium dollar overstate operating expense by close to 4%. The data relied on by the Task Force are not current and ignore efficiency improvements. Third, it is assumed, for reasons I do not understand, that automobile insurers' profit at 2.5% should be accepted as a given in the calculation of what the components of the automobile insurance premium dollar are. If anything comes last on the priority list, it is profit. The inclusion of this item distorts the data, particularly if the data are used in a comparison where profit is not taken into account.

There is no specific reference in the Task Force Report as to what expense efficiency was expected of the no fault plan it recommended,[18] but the Task Force's observations on the efficiency of no fault plans generally (as earlier referred to) suggest that it was proceeding

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[18] See recommendations B. 28, C. 3 and C. 4.

on the assumption a no fault automobile insurance plan could return 80-90¢ of the premium dollar to claimants. The suggestion that any compensation/insurance system for those injured in motor vehicle accidents will return 80-90¢ on the premium dollar to claimants must be an error. Even if the 11% of earned premium allocated to claims adjustment expense was totally eliminated (a prospect no one could seriously suggest will occur in any no fault compensation scheme), no more than approximately 75¢ of the premium dollar could be available to claimants under a pure no fault motor vehicle accident compensation plan.

It may well be that a Workers' Compensation type plan could return 80-90% of earned premiums in benefits.[19] In that environment, coverage is provided on a group, not individual basis. There are no brokers' commissions. The employer takes care of most of the record keeping. Claims-related expenses are reduced because claims are generally processed by the employer. There is a vast difference between that kind of coverage and the coverage provided by either private or public automobile insurers. Finally, on this issue, we can usefully look to the Michigan threshold no fault and the Quebec pure no fault experience. The United States Department of Transport study estimates that Michigan returns 55.1¢ of the premium dollar to claimants.[20] The Quebec experience is dealt with by Professors Fluet and Lefebvre in the 1986 study of

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[19]The WCB in Ontario estimates that approximately 15% of revenues are used for the expenses of the system, an improvement from the former estimate of 18%. The WCB acknowledges that even the 15% figure may be open to some question.

[20]U.S. D.O.T., Compensating Auto Accident Victims...Report (1985).

the Régie. A summary of the study's findings was reproduced as an appendix to the Task Force Report.[21] The Fluet/Lefebvre study concluded that the Régie returned 60% of the premium dollar to claimants in the 1981-1984 period.[22]

In my opinion, transaction costs (mainly defense legal expense) can be reduced in a pure no fault plan. The reduction will likely be in the area of 5% of earned premium. To that extent, pure no fault can be said to be more efficient than the current third party compensation system. I doubt that there would be any reduction in transaction costs in threshold no fault. There is hence no cost efficiency basis on which to proceed to threshold no fault.

Insurers regard party-and-party costs (that is, costs paid to claimants) as part of claims. I will deal with cost reduction at the claims end later in this chapter. For now, I note that in pure no fault what insurers now pay in party-and-party costs will be dramatically reduced because of the elimination of third party claims. The insurer's exposure to party-and-party costs would not, however, be entirely eliminated. Party-and-party costs will still be paid in some disputed first party claims.

In threshold no fault, the reduction in party-and-party costs paid would be less substantial. The

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[21] Ontario Task Force on Insurance, A Pre-Publication of the Final Report (1986), Vol. 2, Appendix 13.

[22] C. Fluet and P. Lefebvre, L'Assurance Automobile au Québec: Bilan d'une reforme (1986).

actuarial data accompanying the I.B.C.'s submission, estimate that the threshold proposed by the I.B.C. although eliminating an estimated 92 out of a 100 claimants would leave 60 out of 100 third party compensation dollars in the system. More than 60 out of 100 party-and-party cost dollars would remain in the system in that in respect of claims eliminated by the threshold, many claimants would not have had legal representation in any event. Those remaining in the system will, by definition, be serious cases in which claimants will be represented by lawyers.

I do not view party-and-party costs, or solicitor and client costs for that matter, to be part of an efficiency analysis that determines what part of the premium dollar is made available to claimants. There is no doubt that when a claimant is represented by a lawyer, claims costs increase in two general respects. First, the insurer will on balance be required to pay more in damages than would be the case were the claimant not represented. Second, the insurer will be required to pay party-and-party costs. These matters were discussed in Chapter 7.

Solicitor and client costs in excess of party-and-party costs, in theory, reduce the plaintiff's compensation. But the claimant is a loser from a financial standpoint only if what the claimant pays exceeds the difference between what the claimant actually received in damages and what the insurer would have paid had the claimant been unrepresented.

Efficiency considerations aside, when a no fault system is being assessed from a comparative cost (and hence premium) standpoint, reductions in compensation paid

for economic and non-economic loss, party-and-party costs, defense legal costs, external adjusting costs, internal adjusting costs, the costs of other experts, administrative expenses and other expenses would make resources available for other purposes. One of those other purposes is the payment of additional first party no fault benefits to provide compensation to those not now eligible to receive it. When all is said and done, history suggests that if premiums are not to be increased, the funding for increased first party benefits can only be obtained by systemically reducing or eliminating existing non-economic loss compensation rights.

(d) Incentives/Deterrence

Those who favour the retention of tort law, suggest accidents will increase if the tort system is discarded in any motor vehicle accident compensation plan. Those who propose no fault reject the tort system's capacity to deter or view its deterrence properties as both minimal and replaceable.

The Ontario Task Force on Insurance seems to have rejected the tort system's capacity to deter, or at the very least regarded it as minimal; the Task Force viewed deterrence as something to be better achieved from outside the compensation system. The Task Force Report put its position on deterrence this way:[23]

> ...the tort-insurance system cannot and does not achieve a significant deterrent objective ... Finally, even

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[23] Supra.

> if these inefficiencies and obstacles could be cleared by a Herculean reform of the tort system, the question of deterrence, given the reality of modern insurance, is one that can be answered outside of tort. To the extent that modern insurance coverage means that in most situations deterrence will be achieved or will be achievable through the vehicle of premium variability or "experience rating", this very mechanism exists and can be worked into any first-party no-tort accident compensation plan. That is, deterrence via higher premium pricing or "penalty rating" is a common feature of many existing first-party no-tort schemes and could easily be incorporated and developed as a component of the no-tort scheme that we set out in more detail below.[24] ... the tort-deterrence debate is ultimately irrelevant.[25]

This is not a simple issue. For purposes of considering deterrence as related to the abandonment of the tort system on the introduction of no fault, we are not really looking at tort law's reasonable person (or driver) or at the economist's rational actor. In the motor vehicle context, it is drivers at the margin who must be taken into account. Any reasonable person will be deterred from reckless or inappropriate driving activity by concern about personal safety, the safety of others, criminal sanctions, etc.

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[24] Ontario Task Force on Insurance, Final Report (1986), pp. 64 and 65.

[25] Ontario Task Force on Insurance, Final Report (1986), pp. 64 and 65.

Proponents of tort law's deterrence-related qualities often put their case too broadly and make claims for the tort system that make very little sense. It cannot be that tort law or the tort system exerts any massive deterrence influence. At that level the argument advanced by those who favour tort law on deterrence grounds flounders. Just as a simplistic analysis of deterrence based upon a consideration only of personal safety and perhaps criminal or regulatory sanction is flawed, so too is the argument that we will in short order be overwhelmed with increased accidents were the influence of tort law to be removed.

In dealing with the extent to which tort law can validly claim to meet deterrence objectives, Professor Schwartz stated at a 1984 seminar:

> When the deterrence argument is stated in a strong form, what is seems to claim is that tort liability should succeed in systematically suppressing negligent conduct. Given, however, the various considerations referred to above -- and given also the incidence of negligent conduct observable out there in the real world -- I regard this strong argument as laughably wrong. Yet the important (and often overlooked) point is this: The falsity of the argument in its strong form leaves entirely open the question of the validity of the deterrence argument in a moderate form, a form that merely suggests that tort liability exerts some measurable (and desirable) effect on the level of risky conduct in society.
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> When moderately stated, the deterrence argument may well be sound. Certainly there is some evidence to support the idea that liability rules play some

> role in the control of risky conduct.[26]

As the deterrence debate develops too much is claimed on the one hand and too little considered on the other hand; in result the deterrence issue often receives flimsy and somewhat cosmetic consideration.

As Dr. White has pointed out in his Inquiry research study, deterrence has different meanings.[27] In dealing with what he characterizes as specific deterrence, Dr. White says this:

> Amongst both traffic safety experts and lawyers, there is the not unreasonable belief that the experience of some driving-related misadventure will affect a driver's behaviour, usually for the better. People tend to underestimate risks to themselves and tend to overestimate their driving abilities as compared to other drivers. Accordingly, they are relatively impervious to public educational messages and other inputs which might improve their driving performance. Although the effect occurs unevenly, it has been shown that accidents, injuries or penalized infractions do tend to sensitize drivers somewhat. ... In the case of specific deterrence, our objective should be to seek the maximum behaviour-change impact from each accident experience. This is not as good as preventing the first accident from occurring, but it does involve a

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[26] Professor Schwartz's address to the Seminar Faculty of Law, Australian National University, Canberra, Australia, August 17-19, 1984.

[27] Inquiry Research Study V.

> significant part of the driver population.[28]

General deterrence is another matter. The principle of general deterrence is part of the vocabulary of those involved in the criminal law, particularly at the sentencing level. General deterrence must focus on those who in the criminal parlance are not yet offenders. Dr. White has correctly identified driver behaviour, in all its aspects, as the primary point of concern. He put it this way:

> In broad terms, the 'what' is accident-producing behaviour, and the 'who' is the not yet accident-affected driver public. To understand general deterrence usefully, the genesis of driving behaviours must be traced, which will give some indication of the 'how'. It is worth noting that imbedded in the term 'deterrence' when applied to MVA (sic) production, there is a double negative: we are speaking of preventing a negative behaviour, when we could as easily be speaking of promoting a positive one.

The deterrence argument, as related to motor vehicle accidents, cannot realistically be viewed from a purely economic perspective. Deterrence in economic terms has much more relevance in the field of products liability. Unlike drivers, manufacturers will be aware of risks and may choose to calculate their cost. Decisions may be made for purely economic reasons. A classic example of this is the famous decision of the Ford Motor Company not to relocate the Pinto gas tank, a decision that was made

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[28] Inquiry Research Study V.

after risk calculation suggested that relocating the gas tank was not cost justified. The problem with the economic or cost benefit approach to negligence and deterrence is that it has no real relevance to driver behaviour.

If, as I think is the case, deterrence has to be looked at from the perspective of its impact on driver behaviour, some consideration has to be given to an analysis of driver behaviour as related to the question of how accidents happen, and how the number and rate of accidents can be reduced.

Dr. White identifies the individual driver's sense of what his or her driver role is as crucial to driver behaviour. The development of appropriate attitudinal responses is thus essential to driver education and traffic safety campaigns.

If tort law, however mysterious it may be to the public, is viewed as imposing liability in response to fault, it seems reasonable to consider what general impact its elimination may have on the driving public. Dr. White makes two valid points: first, changes in social attitudes may well be late blooming; second, the molding of attitudes and roles is central to driver behaviour. Dr. White puts the latter point this way:

> Prevention will be mostly behavioural, and the key behaviour is that of the driver. There is virtually no disagreement that the most important influences on driver behaviour are socio-culturally determined attitudes and roles.

If, as Dr. White claims, there are deterrence-related advantages to the tort system and tort law, their removal will affect behaviour. There may well be substance in Dr. White's conclusion that the tort system may be more important for what it is than for what it does.[29] Tort law, as related to motor vehicle accidents may have some representational significance in the development of appropriate attitudes and roles.

There is also the issue of what impact the introduction of no fault on its own merits may have on attitudes on behaviour and on accidents. It is on this issue that reference is often made to Professor Gaudry's work. I have considered Professor Gaudry's Report on the Régie together with his research study for this Inquiry. I have also spoken at length to Professor Gaudry about the impact of no fault on Quebec motor vehicle accident rates.

Professor Gaudry's massive study of Quebec accident rates following the introduction of the Régie revealed that after the introduction of no fault, there was an increase in motor vehicle accidents of all types; bodily injury motor vehicle accidents (at least one injury, no deaths) increased by 26.3%; fatal accidents increased by 6.8%, and accidents with property damage increased by 11.0%.

Those who support tort law on deterrence grounds look to this data as a basis for the conclusion that the removal of fault, and the introduction of no fault, will lead to an increase in the instance of accidents at all

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[29] See also E.J. Weinrib, "Toward a Moral Theory of Negligence Law," Law and Phil. 2(1983):37.

assessment levels (property damage, bodily injury and fatal accidents). Tempting as this conclusion may be, its validity is called into question by a number of variables referred to in detail in Professor Gaudry's Inquiry research study. Chief among these variables are Quebec's flat premium rating system and compulsory insurance.

In Quebec, all insureds pay the same premium for Régie coverage. No resources at the government insurance level are committed to the determination of fault. Bad risks, which may well have had more accidents and more convictions for driving-related offences, pay the same premium as demonstrably good risks. This results in good risks subsidizing bad risks. Gaudry suggests that flat premium rating led to an increase in the driver population (measured by the issuance of driver permits) and that the driver population increase was weighted in favour of higher risk drivers. Thus, high risk drivers who could not afford to drive and did not drive before Quebec's no fault plan was introduced, became drivers in Quebec's flat premium rating environment. When more high risk drivers are brought into the system, there will be more motor vehicle accidents.

Professor Gaudry has concluded that compulsory insurance may also have had an effect on the rate of motor vehicle accidents in Quebec after no fault was introduced. Although Quebec has had compulsory insurance since 1961, the advent of no fault in 1978 changed administrative procedures so as to require those registering vehicles to pay for Régie coverage at the same time. This put some external teeth in the 1961 compulsory insurance law and resulted in virtually everyone in Quebec being insured. This, Gaudry suggests, worked to reduce levels of care.

The same result was effected as a result of 14 to 18% of uninsured vehicles becoming insured vehicles through the introduction of compulsory vehicle damage coverage. Professor Gaudry's conclusion is that the introduction of no fault in Quebec did have some unquantifiable impact on the Quebec motor vehicle accident rate, but that the no fault impact was small compared to the impact of compulsory insurance and flat premium rating.[30]

I think it should be noted that there may well be a distinction between measuring the impact of no fault schemes on accident rates and assessing the capacity of the tort system to deter unacceptable driving behaviour. In addition to Gaudry's work, there have been several empirical studies which have sought to determine whether the adoption of no fault or modified no fault laws affects accident rates.[31]

In a study of accident rates in 16 American states which adopted threshold no fault laws between 1971 and 1976, Elizabeth Landes concluded that, except for states with very low thresholds, no fault produced a statistically significant increase in fatal accidents and accident costs.[32] Subsequent studies have criticized

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[30]Professor's Gaudry's Inquiry Research Study I.

[31]See C.J. Bruce, "The Deterrent Effects of Automobile Insurance and Tort Law: A Survey of the Empirical Literature," Law and Policy 6, no. 1 (1984):67.

[32]E. Landes, "Insurance, Liability, and Accidents: A Theoretical and Empirical Investigation of The Effect of No-Fault Accidents," J. of L. and Econ. 25 (1982):49.

Landes' methodology and rejected her conclusions.[33] After analyzing data from all 50 states and the District of Columbia in the years 1967 to 1980, Zador and Lund concluded there was no support for the claim that adoption of no fault laws increased the frequency of fatal accidents.[34]

Another study by Kochanowski and Young reached similar conclusions.[35] Using cross-sectional data from each U.S. state for the years 1975, 1976 and 1977, the authors attempted to explain fatal accident rates in each state as a function of the characteristics of the state's licensed drivers, driving environment and whether or not the state had no fault automobile insurance. The authors found that driver characteristics significantly influenced fatality rates. Kochanowski and Young found fatalities were more likely to occur in states with a relatively high percentage of young drivers, in states where the licensed driving population was heavily dominated by male drivers and in states with relatively lower per capita incomes. As to environmental characteristics, other things being equal, the study concluded that fatality rates were lower in more densely populated states. Although the authors stated unequivocally that no fault automobile insurance

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[33] See e.g., O'Connell and Levmore, "A Reply to Landes: A Faulty Study of No-Fault's Effect on Fault?" No. L. Rev. 48 (1983):649; Sugarman, "Doing Away With Tort Law," pp. 588-90.

[34] Paul Zador and Adrian Lund, "Re-Analyses of the Effects of No-Fault Auto Insurance on Fatal Crashes," J. of Risk and Ins. (June 1986):226.

[35] Paul Kochanowski and Madelyn Young, "Deterrent Aspects of No Fault Automobile Insurance: Some Empirical Findings," J. of Risk and Ins. (June 1985):269.

was not associated with higher fatality rates, their results did not suggest that no fault insurance would lead to a significantly safer driving environment and fewer fatalities.

The 1985 U.S. Department of Transportation (DOT) Study analyzed both the before and after experience of the 16 states that adopted threshold no fault in the early 1970s compared with the 34 states that retained tort or adopted add on systems; the study concluded that no fault automobile insurance did not have any measurable effect on fatal accident rates.[36]

What reasonable conclusions emerge from all of this evidence? I start that exercise by noting a negative. There seems to me to be no credible evidence to suggest that eliminating tort law and substituting no fault will decrease accident frequency. Equally, looking at the empirical evidence as a whole it is difficult to draw the conclusion that no fault has caused a significant adverse effect on accident rates. Nor does the evidence seem to suggest that tort liability exerts any statistically measurable effect on the level of safe driving.[37] But this does not end the matter. The study done by Professor White and the observations of Professor Schwartz give force to the argument that the tort system still performs some modest deterrent function in the motor vehicle context, even if its impact is not empirically demonstrable.

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[36]U.S. D.O.T., Compensating Auto Accident Victims...Report (1985), pp. 159-165.

[37]See Sugarman, "Doing Away with Tort Law" at p. 587.

Intuitively, I agree with Dr. Wilde's observation that if an event (a motor vehicle accident) is generally to be viewed as being less serious in no fault because no blame in the civil sense is attached to it, there may be more accidents. Professor Wilde put it this way:

> In passing it may be noticed that the subjectively perceived cost of an accident may be different under "fault" versus "no fault" insurance. If no fault insurance is interpreted by drivers as "no blame" or in any other way reduces the expected seriousness of accident consequences, then an increase in the accident rate must be anticipated from a change-over from "fault" to "no fault" insurance. This view is apparently not shared by O'Connell who wrote: "Nor need we fear that an increase in victims' faulty conduct will result form (sic) paying faulty and faultless accident victims alike" (p. 70 in O'Connell, J. "Tort versus no fault: Compensation and injury prevention." Accident Analysis and Prevention 19, (1987), p. 70. However, close reading of this paper reveals that O'Connell himself is not positively confident of that statement and that he favours no fault insurance primarily for reasons other than safety considerations. Moreover, O'Connell's statement appears to be contradicted by the increase in accidents that followed the introduction of no fault insurance for corporal damages (injuries and fatalities) in the Province of Quebec in March 1978, but it should be noted that the new law encompassed other elements as well.[38]

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[38] Gerald Wilde's Inquiry Research Study VI: Incentives for Safe Driving and Insurance Management.

Just as Professor Schwartz suggests that massive claims of deterrence/incentive benefits cannot realistically be made for tort law, massive denunciations of tort law's capacity to deter are not justified. In some cases, driver behaviour may be marginally but positively affected, not by tort law as such, but by what it stands for; moreover, even if the concepts of fault and responsibility exert no positive deterrent influence, the introduction of a no fault compensation plan may well have a modest adverse effect on driver care. This will not occur overnight. It is the "no blame" perception which is important as related to driver behaviour. This perception will not be altered by using an ambiguous titular reference such as "no tort".

Apart from the suicidal, there is no doubt that drivers do not intend or want to be involved in an accident. Some drivers, however, seem to believe that however fast or reckless their driving may be, they will somehow not have an accident. For that group, the prospect of criminal sanctions is too remote. The Highway Traffic Act's penalties are seen as a cost of mobility. For that fringe group, the prospect of formalized responsibility through tort law and the tort system may work in some small but real way to deter the kind of driving behaviour that leads to accidents. At that level, deterrence may be lost by converting from the tort system to a no fault system.

Conclusions on the deterrence issue must remain somewhat uncertain. Nevertheless, if we are rightly concerned about social attitudes and their appropriate development in the context of driver behaviour, then we should be cautious about doing anything which might

adversely affect attitudes of basic responsibility. Accountability, however abstract and even mysterious it may be in its manifestation, may well in the longer term support the development of what Dr. White refers to as the "'competent and responsible' driver role".[39] Given the huge social cost of motor vehicle accidents in our society, one must question the appropriateness of abolishing a system which may exercise some effect on accident prevention even if that effect cannot be measured statistically. Moreover, even if the tort system is taken to have no capacity to deter in its own right, it may well be that the introduction of no fault compensation will lead to some, probably slight, reduction in driver care.

(e) Fairness

The tort system/no fault debate often begins and ends with the consideration of compensation and deterrence-related issues. I think, however, that much more than a consideration of those two issues is required.[40] Tort law's capacity for fairness and justice should not in my view be ignored. The public's sense of justice, of what is fair and reasonable, must be taken into account.

The moral values implicit in tort law, seem to me to be both understood and agreed to by a substantial majority of drivers who may not know what tort means, or what tort law is, but who do appreciate what it stands for. As

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[39] Norman White's Inquiry Research Study V: The Function of Deterrence in Motor Vehicle Accident Compensation Schemes, p. 457.

[40] These were the two principal issues considered by the Ontario Task Force on Insurance in its assessment of the tort system's objectives.

related to motor vehicle accidents, the public understands and accepts the rules of the road. The concept of some individual responsibility for individual actions, at least in a humanely modified form, is central to what reasonable people regard as just.

In dealing with the issue of fairness, Professor Schwartz commented:

> . . . For the negligence standard lies at the foundation of tort law in Australia, and that standard can be explained in terms of the simple idea that if you "behave improperly and thereby injure another, you are responsible for the consequences". The correctness of this simple idea seems obvious and commonsensical. I should note, however, that the idea's common sense status has recently been disputed by the Oxford Centre which suggests that the idea may be no more than a temporary mood of the particular time and culture. In fact, however, the fairness idea behind the negligence rule can be easily aligned with notions of corrective justice set forth by Aristotle in ancient Greece. (If anything, it is the assumptions on which the Oxford Centre relies in recommending a comprehensive compensation program that are highly vulnerable to the charge of historical and cultural relativism). I should also take care to distinguish the fairness objective I am here describing from what Professor Fleming has referred to as the objective of punishment of the tort feasor. In my description, what is at stake is interpersonal fairness between the defendant and his victim rather than any societal condemnation of the defendant.
>
> . . . The fairness argument stated above has been explained in terms of the improper conduct of the defendant. In the view of many, however, "improper conduct" is a misleading way of characterizing actual negligence. As Keeton O'Connell Report, a motorist is required to render hundreds of observations and judgment calls on an hourly basis; the impression the authors obviously mean to convey is that

> negligence is a random matter, basically excusable on the part of the motorist. In his subsequent writing, Professor O'Connell has extended this point by way of suggesting as a general matter that tort accidents come about in circumstances that are "morally neutral". . . .
>
> The moral neutrality thesis may seem more nearly plausible with respect to highway accidents: as each of us drives by an accident, we may be inclined to say, there but for the grace of God go I. However: if we look at available highway accident statistics, the information we find suggests that negligent motoring need not be sharply divorced from basic notions of wrongdoing.[41]

The moral neutrality of some motor vehicle accidents cannot withstand even anecdotal analysis. Is there anything morally neutral about drinking and driving? Some driving conduct is so manifestly negligent that its relegation to irrelevance would be regarded by many as offensive. This concern, of course, can be alleviated, but not eliminated by increased use of criminal sanctions for inappropriate driving behaviour, and by (the prospect of) increased insurance premiums.

Those in favour of the tort system often cite the example of the drunken driver who crashes into the back of a motionless vehicle with the result that both drivers are seriously injured. The idea that both the innocent and the drunken driver should be compensated equally tends to offend many people's sense of justice.[42] The moral issue

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[41] Professor Schwartz's address to the Seminar Faculty of Law, Australian National University, Canberra, Australia, August 17-19, 1984, pp. 71 and 72.

[42] See Dunlop, "No-Fault Automobile Insurance and the Negligence Action," p. 446.

raised by this example becomes even more difficult when no fault benefits are increased. Cases of this kind are few in number, but they do serve to emphasize the importance of the idea of fairness in our society's system of values.

It is the public's sense of fairness which has caused the no fault movement in the United States to stall, if not stop. When the public finds out about no fault's values, or perhaps the elimination of tort law's values as Professor Schwartz says: "It tends not to like it".[43]

Professor O'Connell, an eloquent and convincing proponent of no fault, blames the United States' personal injury bar and the politicians for the pervading legislative inertia in the no fault movement. In the Canadian context, I find Professor O'Connell's explanation unconvincing. If no fault has floundered here, it is not because of a focused opposition by lawyers or others somehow having a vested interest in tort law, but rather because of an unfocused opposition by the public which has been reflected by members of the Legislature of all parties. I do not regard this as something sinister. It is the way our system should work, if in at least some respects, public policy decisions made at the political level are to respond to, rather than establish, public expectations. How else can it be explained that in submissions made to this Inquiry, no major public interest group or political party has proposed a full no fault system of compensation.

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[43] Professor Schwartz's address, p. 74.

Threshold no fault's proponents seem to recognize that the public's expectations and sense of fairness would be offended if the more seriously injured were not permitted to have access to compensation for both economic and non-economic loss, assessed on an individual, case-by-case, basis. Threshold no fault is driven by that social concern and from the insurance industry's standpoint, by a need to limit third party costs, so that increased no fault benefits can be paid to all those injured in motor vehicle accidents.

The 1973 Ontario Law Reform Commission Report, the 1978 Report of the Select Committee on Company Law, and the 1986 Ontario Task Force on Insurance Report all considered the issue of the public's sense of justice and fairness, as related to the elimination of tort law and the introduction of no fault. The 1973 O.L.R.C. Report dealt with the fairness issue this way under the heading of "Public Acceptability":

> ...An analysis of the various studies leads to the conclusion that much of the attitude of the public towards the question of the negligence action versus no fault insurance is based on a misunderstanding of both forms of reparation. It is also reasonable to conclude that given an understanding of what is involved in the two systems the majority of the people would favour no fault. The fact that no fault schemes have been adopted with beneficial consequences in a number of jurisdictions in recent years, and the promotional material on behalf of no fault systems, has begun to issue from the insurance industry itself, tends to increase the reliability of this conclusion.[44]

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[44] O.L.R.C., Report (1973), p. 79.

The 1978 Select Committee on Company Law took into serious account what it viewed as the public's sense of justice and fairness in making its somewhat complex, and I might add, extremely costly recommendation as to an appropriate compensation system.

The Ontario Task Force on Insurance Report, in dealing with the question of public acceptability, stated:

> The Task Force recognizes that these recommendations will raise many questions about design and content. There will also be some opposition and objection in principle. However, most of the objections to no-tort compensation tend to disappear with explanation and education. Many of the questions have already been answered in the literature.
>
> The Task Force has not examined every detail in the design or delivery of a no-tort accident compensation system but it is confident that these details can be worked out through good-faith effort and an open-minded attitude.[45]

I think it more than questionable that given explanation, education, understanding, and endorsement by the insurance industry and a majority of the academic community, the public will regard the total abandonment of fault in the compensation process as fair and just. Perceived fairness and the total abolition of fault are not likely to co-exist in any compensation system even with explanation, education and understanding.

In my opinion, the public's sense of fairness will not be satisfied if fault is left to be dealt with solely through the criminal justice system and the premium

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[45] Ontario Task Force on Insurance, Final Report (1986), p. 69.

rating system. The public's sense of what is right requires that fault be taken into account in the compensation process and, where required, in the criminal or quasi-criminal justice system.

Further, the allocation of fault for premium rating purposes is deceptive. In a no fault compensation scheme, fewer resources will be committed to fault. In a no fault environment, fault is less relevant from an insurance standpoint than it is in any system where at least some entitlement to compensation is based on fault. From a premium rating standpoint, good drivers represent a much more significant risk to a no fault system than is the case in a fault-based system. In a no fault system, the insurer has to consider the probability of an insured being in an accident, whether or not that accident will be the insured's fault. In a no fault system, an accident alone triggers the insurer's obligation to pay stipulated benefits; in a fault-based system, not only must there be an accident, the accident must be the insured's fault in order to trigger the insurer's obligation to make third party payments. It follows that as a premium rating factor, fault is of far less significance in no fault than it is in any fault-based system of compensation.

The rather hardy nature of fault was recently considered by Professor Trebilcock who put it much better than I can in saying:

> ...I cannot conceive of an ethically attractive society in which all semblance of individual responsibility for misfortunes inflicted on

> others or oneself (sic) is treated as entirely irrelevant to the compensation equation.[46]

(f) Insurance Compatibility

The insurance industry's position on the no fault issue is separate from the industry's capacity to deliver benefits as required in any recommended compensation scheme. I am satisfied that the industry's flexibility is more than sufficient to deliver benefits and compensation in any reasonable compensation scheme.

E. THE I.B.C. SUBMISSION

I do not intend to canvass the many general submissions made to the Inquiry as to the type of compensation system Ontario should adopt. Two specific proposals do, however, require and deserve comment. They are the I.B.C. threshold no fault proposal and the Ontario Task Force on Insurance Report's recommendation of pure no fault automobile insurance as a first step to a more comprehensive no fault compensation plan.

Before I deal specifically with the I.B.C. threshold no fault proposal and the Ontario Task Force on Insurance's no fault recommendation, I should comment on the policy which underlies the threshold no fault concept. Looked at from the insurer's perspective, the principle underlying threshold no fault is cost-based. To maintain any increase in first party benefits, the insurance industry contends that costs must be reduced on the third party side or premiums will inevitably rise. Those who

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[46] Trebilcock, Where Does the Buck Stop?, p. 30.

propose threshold no fault seem to be ever mindful of this need for first/third party cost balance. The threshold has to deny compensation for pain, suffering and loss of enjoyment of life to a sufficient number of claimants to achieve savings sufficient to offset increased costs attributable to the provision of enhanced no fault benefits.

The I.B.C. submission was by far the most comprehensive submission I received on the issue of what compensation system Ontario should adopt. The I.B.C. submission was accompanied by actuarial data containing cost estimates; in that costing, reserves were discounted. Although some of the actuarial assumptions might be questioned, it can be said that the I.B.C. actuarial data and the actuarial data obtained during the course of this Inquiry for the first time make it possible to predict with some reasonable degree of accuracy what effect different compensation proposals will have on loss costs and, hence, on premiums. This is a major advance. Earlier no fault recommendations were conceptual only. The consumer is far less interested in concepts than in premiums. Consumers are entitled to know approximately what any proposed compensation plan will cost.

Some who criticize the tort/insurance system for overcompensating the less seriously injured, support threshold no fault because the threshold will work to keep less serious cases out of the tort system; less serious cases will be denied access to compensation for pain and suffering, even if the injury giving rise to the pain and suffering was caused by the negligence of another. To a certain degree, this rationale was adopted by Professor Brown who assisted the I.B.C. in developing its threshold

no fault submission to this Inquiry. At the beginning of Professor Brown's comments in the I.B.C. submission, he states:

> A modified no-fault plan reflects the judgment that relatively minor injuries are adequately compensated by provisions covering economic loss (especially rehabilitation expenses). In such cases, compensation for non-pecuniary loss is not necessary.[47]

It seems to me to be somewhat perverse to purport to resolve an overcompensation problem, at least in the area of non-pecuniary loss, by paying no compensation at all.

After introducing the I.B.C. concept of threshold no fault as indicated above, Professor Brown proceeded to explain the I.B.C. proposal on a pure cost basis:

> In formulating a threshold for non-pecuniary tort claims it is necessary to draw the line between serious and non serious injury in such a way as to achieve sufficient savings to fund the no-fault economic loss benefits (thus keeping the plan "in balance") while being fair to victims.[48]

It is plain that the I.B.C. threshold is designed to keep claimants out of the system for cost reasons, not to let the seriously injured in. In 1978, the Select Committee on Company Law looked at the issue differently, emphasizing public expectations in recommending that the seriously injured be permitted to recover non-pecuniary compensation through tort law.

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[47] Submission of the Insurance Bureau of Canada, Appendix 3, p. 1.

[48] Insurance Bureau of Canada's submission, Appendix 3, p.1.

The I.B.C. threshold no fault submission recommends a substantial increase in first party no fault benefits and a verbal threshold limitation on a claimant's right to recover non-pecuniary damages through tort law. In very broad terms, the increase in costs attributable to paying more no fault benefits to more claimants is, for the most part, absorbed by reducing the number of claimants who would otherwise have a right to recover compensation for pain, suffering and loss of enjoyment of life.[49]

The I.B.C. threshold is generally modelled after the Michigan threshold no fault plan, but the threshold language is even more restrictive than Michigan's in its application.[50] The Michigan threshold excludes those who have not sustained a "serious impairment of body

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[49]There may be some reduction in transaction costs but as earlier indicated transaction cost savings in threshold no fault are questionable.

[50]The I.B.C. proposed threshold reads as follows:

> "A person remains subject to tort liability for non-economic loss caused by his or her ownership, maintenance or use of a motor vehicle only if the injured person has suffered death, permanent serious impairment of a body function or serious permanent disfigurement.
>
> (a) Permanent serious impairment of a body function means: An objectively manifested impairment of an important body function which permanently affects the general ability to lead a normal life.
>
> (b) Permanent serious disfigurement means: An injury which impairs the beauty, symmetry or appearance of a person and renders it significantly unsightly, mis-shaped or deformed in some manner."

function". The I.B.C. proposed threshold excludes those who have not sustained an injury resulting in a "permanent serious impairment of a body function". The I.B.C. threshold is more restrictive because of the introduction of the word "permanent" and because of the I.B.C's proposal as to how the threshold should be applied in bodily injury cases.[51]

The Michigan threshold and the I.B.C.'s proposed threshold both permit third party tort claims in fatal accident cases and cases which involve cosmetic injuries (scarring) resulting in serious permanent disfigurement.[52] Most of those injured in motor vehicle accidents are neither killed, nor suffer a serious permanent disfigurement.

In assessing the I.B.C. threshold no fault proposal, it is useful to consider how it would be determined that an injured plaintiff met or passed the threshold in order to claim non-pecuniary general damages. In order to be entitled to non-pecuniary compensation, the plaintiff's injury must:

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[51] The I.B.C. proposal adopts Cassidy standards. See Chapter 11.

[52] The Michigan threshold uses "permanent serious disfigurement". I have assumed the order of the words "permanent" and "serious" is not material.

(a) be objectively manifested;

(b) impair an important body function;

(c) be permanent;

(d) be serious;

(e) permanently affect the plaintiff's general ability to lead a normal life.

The United States Department of Transport has estimated that the Michigan threshold excludes 89% of those injured from access to non-pecuniary general damages. The I.B.C. estimates its threshold would exclude 92% of those injured. If the I.B.C. threshold were applied as suggested in the I.B.C. submission, I think that fewer than 8 out of 100 plaintiffs would pass the I.B.C. threshold. The I.B.C.'s actuary has conceded that the 92% figure is no more than an estimate and may well be too low. If the DOT Report of the Michigan experience is accurate (as most think it is) the I.B.C. has in all likelihood underestimated the percentage of claimants excluded from non-pecuniary compensation.

While the purpose of the exercise is to determine whether a given plaintiff is entitled to non-pecuniary compensation to be assessed by a judge or jury on a purely individual basis, a major ingredient of the I.B.C. threshold determination ignores the plaintiff's individual lifestyle completely. This arises out of the requirement previously referred to that the injury be such as to permanently affect the claimant's general ability to lead a normal life. The question arises: normal for whom? The I.B.C. submission provides a clear answer. It states:

> On the other hand, interference with normal lifestyle is to be determined by an objective

> evaluation of the effects of the injury on the person's body functions and the ability to perform day-to-day activities and not by extrinsic considerations such as the nature of the person's employment. The objective "normal lifestyle" standard has been left undefined. Certain types of employment, athletic and social activities are irrelevant to the standard. (emphasis added)

It is apparent that the I.B.C. views the plaintiff's employment, social activities, etc. as "extrinsic considerations". This troubles me because it requires the trial judge or jury to conjure up a vision of a normal lifestyle (whatever that is). A determination must then be made as to whether the injury has permanently affected the claimant's ability to lead a lifestyle which the claimant may never have led, or for that matter, never wanted to lead, in the first place. At the eligibility level, that approach seems to me to amount to little more than a sophisticated and thinly disguised meat chart imposed for the singular purpose of ensuring that for purely cost reasons, a pre-determined number of injured claimants is excluded from access to non-pecuniary general damages.

There is a further problem with the I.B.C. threshold because of a confusion between injury and disability. The I.B.C. threshold, requires that a claimant's injury be "objectively manifested". The objectively manifested test amounts to an eligibility by x-ray requirement. It is the disability, more than the injury, which is significant. The extent to which a given injury will disable a claimant will depend on a number of factors, including the claimant's vulnerability to injury. Many soft tissue injuries will not pass the "objectively manifested" test. Whether the plaintiff's evidence as to

pain and suffering or impairment of body function (i.e., disability) is accepted or rejected, the plaintiff will fail the threshold test if the injury (as distinct from any resultant disability) is not objectively manifested. Because of this somewhat harsh requirement, in Michigan, the courts have accepted thermographic evidence. The legal/scientific legitimacy of the use of thermograms to satisfy the objective manifestation test seems to me to be questionable in the extreme. It is an illustration of what will be done when justice demands it.

As has been pointed out by a number of insurers' representatives, the threshold can be adjusted. Given its cost-based rationale, the extent to which the threshold excludes claimants is, of course, crucial. If the threshold were to be modified, insurers emphasize that more claimants would be permitted to recover non-pecuniary general damages. If that happens, it follows that third party costs would rise and the system may not continue to be in balance, in the sense that increases in first party no fault costs would not be offset by decreases in third party costs.

It seems to me to be inappropriate to deny non-pecuniary general damages to at least 92 out of 100 injured claimants in order to secure a cost reduction which the I.B.C. submission estimates will be about $71 a car. Moreover, as a number of insurers have emphasized, the cost reduction of approximately $71 a car will not result in an equivalent premium reduction because it is premised on premiums being at a reasonable level now. Insurers generally take the position that premiums are now too low.

The I.B.C. proposal is generous in its provision of some no fault benefits. Income replacement benefits are more realistic than is the case now. Rehabilitation is unlimited. A separate long-term care benefit limited to $200,000, is proposed. The long-term care provision excludes compensation for care provided by members of an insured's family, a provision I find unacceptable. In the I.B.C. proposal, long-term care is limited to the lesser of the monthly cost of group residence or the monthly cost of long-term care not exceeding twelve hours per day.

The I.B.C. has proposed non-primary disability benefits to age 65 based upon 90% of net income up to a maximum of $600 a week. The cost of this benefit is modest because it will be paid only after Workers' Compensation, Canada Pension Plan benefits, employers and other group salary-continuation plans, unemployment insurance disability benefits and government assistance programs are first taken into account. By including Workers' Compensation on a list of primary payers, I assume the I.B.C. is prepared to abandon the current Workers' Compensation exclusion contained in Section B of the automobile insurance policy. Individually purchased loss of income protection will be prorated. Students and the seasonally employed are eligible for no fault benefits. I endorse their inclusion in the no fault package.

Homemakers continue to be dealt with separately, and in my view, inappropriately. To be entitled to the $200 a week homemakers' benefit (an increase from $70 a week), the injured homemaker must be totally incapacitated. Why the standard of disability for homemakers should be different from those otherwise employed, escapes me. I do

not share the insurers' concern about the potential for fabrication of disability. It seems to me that if homemakers are injured, their disability should be assessed on the same basis as any other person's disability.

The I.B.C.'s proposed death benefit is primary and is based upon the status of the deceased at the time of death. The minimum death benefit is $10,000. I have no serious quarrel with the quantum of the death benefit, although it seems to me that a policy decision should be made as to whether the purpose of the death benefit is to compensate for economic loss or simply to recognize the value of a life in some tangible way. The problem with gearing the death benefit to income, and at the same time ignoring collateral benefits, as the I.B.C. proposes, is that the benefit will tend to compensate those who need compensation least.

The I.B.C. actuarial data, using discounted reserves, indicate that the increased no fault benefit package proposed by the I.B.C. will result in an increased cost per car of $63.22.[53] Because of the threshold exclusion, bodily injury costs will decline by $134.20. This will result in a reduction in loss costs per car of about $71 as previously mentioned. The I.B.C. cost savings estimate is necessarily an approximation. It does not take threshold-related transaction costs into account; further, some of the actuarial assumptions are questionable, in particular the assumed 10% collateral source offset. No

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[53] See I.B.C. submission, Appendix 1, Exhibit 1.

reasonable purpose would be served by further examining the I.B.C. cost savings estimate.

The insurance industry's position on compensation-related issues is not hard to understand. From the industry's standpoint, no fault provides an atmosphere of stability and predictability compared to our present system. I am not naive enough to think that the insurers' threshold no fault proposal is the product of their belief in the consuming social benefits of that kind of compensation scheme. If that were the case, one might wonder why the industry had not officially taken a threshold no fault or some other no fault-related position in its submission to the Ontario Task Force on Insurance. The I.B.C. did propose a form of no fault in the 1970s (Variplan). When it was not accepted, the insurance industry took a somewhat neutral position on the no fault issue. Nevertheless, the fact that the insurance industry supports a given compensation plan is important. It provides evidence that benefits as proposed can be delivered, and I would assume in the case of the I.B.C.'s proposal, at least at the cost outlined in the actuarial data provided with the submission.

In supporting the I.B.C.'s threshold no fault plan, spokesmen for the I.B.C. and individual insurers have submitted that in a first party compensation environment, the claimant would be dealing with his own insurer, not the insurer of the at-fault party. Insurers suggest that this should lead to a more amicable relationship between claimant and insurer, and to an emphasis on service, responsive to an awareness that an unhappy customer will change insurers. Insurers contend this will provide an incentive for claims personnel to deal quickly, fairly and

efficiently in claims and resolving any disputes that might arise.

This argument has a superficial appeal to it; there is, however, nothing in the history of the delivery of Section B benefits, of compensation under SEF 42 or SEF 44, or compensation under unidentified/uninsured motorist coverage (all provided at the first party level) to suggest that first party claims will be handled with more affection and less delay than is the case now. If there is any pervading shortcoming within the insurance industry at the claims level, it is in the delivery of first party benefits. It is unlikely that upon conversion to some kind of no fault compensation plan, claims-related dealings between insurer and insured will suddenly be dramatically improved.

F. THE ONTARIO TASK FORCE ON INSURANCE REPORT

The Ontario Task Force on Insurance recommended that Ontario adopt a no fault automobile insurance plan as a first step to a more comprehensive accident/disability compensation plan. The Task Force was established as a result of the liability insurance crisis of 1985-1986. In summarizing its preliminary conclusions as to the existing problems, the Task Force Report states:[54]

> First, the heavy concentration of problems in general liability insurance lines is an unusual feature of this cycle. It has been argued here, and will be argued more fully in Part B, that the general liability area has been most severely hit

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[54] Ontario Task Force on Insurance, Final Report (1986), p. 23.

by the fundamental structural changes in technology, in societal values and in the practice of civil law that we are currently experiencing. It is therefore in this area of insurance that the Task Force has focused much of its attention.

Second, a number of longer-term trends have significantly influenced various aspects of risk and insurance and compensation. Thus, although there is no general crisis of price or availability of personal automobile insurance in Ontario, (emphasis added) there are clear indications of a trend of increase in the real cost of claims for bodily injury, together with indications of a trend towards a more litigious approach to such claims. These trends have little to do with the insurance cycle, but they have become more visible as the trough of the shift to a hard market has approached.

The Task Force's recommendations on automobile insurance are located in Parts B and C of its Report. Part B of the Task Force Report deals with the "Crisis in Liability Insurance"; Part C deals with "Other Insurance Issues", including automobile insurance.

Recommendation B.28 provides:

> B.28 In the short term, a new accident compensation scheme should be implemented by the private insurance industry at least for automobile accident injury. (This proposal is developed in more detail in Part C.)

Recommendations B.29 and B.30 are the Task Force's medium-term and long-term recommendations. Those recommendations are:

> B.29 Ideally and as a medium-term objective, government should begin to work with the private insurance industry to design a universal accident compensation plan that

would include compensation for all accidental injuries.

B.30 Eventually and in the longer term, federal and provincial governments should begin planning the co-ordination and rationalization of all existing first-party no-tort compensation schemes into a universal disability compensation program.[55]

In that part of the Report dealing specifically with automobile insurance, the Task Force makes a similar, but perhaps less positive no fault automobile accident compensation recommendation. Recommendation C.3 provides:

C.3 The Government of Ontario should consider elimination of resort to the tort/litigation system with respect to personal injury compensation from automobile accident; or

C.4 The Government of Ontario should consider substantially limiting resort to the tort/litigation system with respect to personal injury compensation from automobile accidents, by way of a threshold.[56]

Having concluded that there was a serious problem in liability insurance and that there was no similar problem in automobile insurance, it becomes somewhat difficult to assess the basis in principle upon which the Task Force proceeded to its no-tort automobile insurance recommendations. The Task Force's approach to automobile insurance has resulted in many suggesting that "if it isn't broke, don't fix it". I have difficulty in

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[55]Ontario Task Force on Insurance, Final Report (1986), p. 69.

[56]Ontario Task Force on Insurance, Final Report (1986), p. 80.

wholeheartedly endorsing this caveat because in my view there were and are problems in automobile insurance. Perhaps a better approach might be "if it can be effectively repaired, don't demolish it".

The Task Force's approach to resolution of the liability insurance crisis through the demolition of the tort system generally mirrors that taken in the 1983 Products Liability and Personal Injury Compensation in Canada study done for the Federal Government.[57] The Task Force seems to have concluded that there is a lack of rationality in the manner in which we compensate those injured in accidents. It dismissed the tort system on compensation, deterrence and efficiency grounds; that having been done the Task Force recommended a "no-tort" system of compensation.

As applied to automobile insurance, the rationale underlying the Task Force's no-tort recommendation seems to have been that the perceived need to take the first step (the elimination of tort for compensating those injured in motor vehicle accidents) so as to make it more likely that the Task Force's medium and long-term recommendations might be implemented.

It seems to me that establishing a no fault automobile insurance compensation plan as a first step to a more comprehensive no fault compensation scheme might actually make it less likely, not more likely, that a more

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[57] E.P. Belobaba, Products Liability and Personal Injury Compensation in Canada: Towards Integration and Rationalization (Ottawa: Consumer and Corp. Affairs Canada, 1983).

comprehensive compensation package could eventually be implemented. Professor Philip Osborne has noted that if no fault is undertaken incrementally, with generous income replacement benefits, it might well be more difficult to proceed to a workable comprehensive compensation scheme because benefits would have to move to the highest existing benefit level.[58]

The first step no fault automobile insurance approach is dependent on the feasibility of the second step. Ontario is not remotely close to considering, let alone adopting, a comprehensive accident or disability compensation scheme. No fault automobile insurance has to be considered on its own merits.

On a more specific level, the Task Force's efficiency assumptions both as related to the tort system and as to no fault seem to me to be in error. I will not repeat what I said earlier except to note that a no-tort system in which policies are sold on an individual basis, cannot return 80 to 90 cents of the premium dollar to claimants.

The Task Force's alternative threshold no fault recommendation (recommendation C.4) seems to me to have been somewhat cautiously advanced. The Task Force Report says this about threshold no fault:

> Having said this, however, if the decision is nonetheless made to preserve the tort/litigation

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[58]Meeting with Philip Osborne, Winnipeg, Manitoba, April, 1987. The thesis is that no fault benefits in existing compensation plans could not, in practical terms, be lowered as part of a comprehensive accident or disability compensation plan.

fragment for use in special circumstances, the difficulty remains in designing the appropriate 'threshold'. Should it be a 'monetary' threshold that would permit litigation when actual or anticipated income losses exceed those offered under the basic insurance plan? Or should it be a 'verbal' threshold that would attempt to reserve access to tort for those cases where serious injury has resulted in 'loss of a bodily function or permanent disfigurement'? Both of these approaches present further difficulty. If the threshold is a monetary one geared to excess-income claims, does it make sense to retain the tort vehicle for these situations? The only persons who would resort to lawsuits for these excess economic claims would be those who had chosen not to purchase additional layers of coverage. If this is so, would there not then be cross-subsidization of the higher-income earners? And if a verbal threshold is employed so that non-pecuniary recovery can be obtained for the permanently disabling injury, does it make sense to preserve tort litigation given the 'cap' on pain and suffering, and given that in any event this item of intangible injury could be made a component of the basic first-party no-tort insurance package?[59]

As can be seen from the above, the Task Force's enthusiasm for a threshold no fault scheme was distinctly limited. I share that enthusiasm.

I agree with the Task Force's conclusion that continued use of the tort system on its own cannot be justified on compensation grounds. This, however, does not seem to me to require abandonment of the tort system. Compensation deficiencies of the tort system can be accommodated by a soundly structured no fault benefit package for those injured in motor vehicle accidents. The

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[59]Ontario Task Force on Insurance, Final Report (1986), p. 80.

Task Force did not seem to consider this accommodation as a viable option. I take a somewhat different view from the Task Force on the deterrence issue. Beyond that, there are benefits to the tort system beyond compensation and deterrence which must be taken into account.

G. GENERAL CONCLUSIONS

A motor vehicle accident compensation system should deal humanely with all those who are injured, and provide reasonably generous rehabilitation and long-term care benefits on a no fault basis while at the same time preserving a compensation distinction between those who cause accidents and those who do not.

I reject threshold no fault. Threshold no fault is relatively inefficient and unnecessarily arbitrary. There will either be no, or minimal, savings on transaction costs in threshold no fault. However precise the threshold may be, there will inevitably be disputes about who is out and who is in. I think it is abundantly clear that cost is the singular rationale underlying threshold no fault. That makes a consideration as to who is in and who is out in human terms redundant and irrelevant. To provide reasonable no fault benefits and at the same time to be cost effective, the threshold must deny non-pecuniary compensation to a substantial number of accident victims who would otherwise be entitled to such compensation. That is necessarily arbitrary and in many instances unfair. This threshold exclusion cannot be justified on the basis of excluding small cases from the system. In their application, thresholds, to be cost effective, must exclude many cases that no one could suggest involve minor injuries.

I reject pure no fault on fairness and deterrence grounds and because it is manifest that few seem to want it. From a cost efficiency standpoint, there are clear benefits to pure no fault compensation. Nevertheless, appropriate social policy cannot be judged solely on a cost basis. Inquiry hearings have led me to conclude there is little public demand for pure no fault and that there would be a great deal of public resentment were it to be implemented. I make no apology for considering what I perceive to be the public's response on this issue.

Many of those who favour no fault suggest that the injured should not be compensated for pain, suffering, etc., because people do not typically insure themselves against that loss. I find this argument unconvincing. Insurers do not provide that coverage, and as Professor O'Connell somewhat facetiously noted, if they did, insurers would likely decline to sell first party pain, suffering, etc., coverage to anyone who wanted to buy it (on moral hazard grounds).[60] Moreover, stretching matters somewhat, it might be said that the 95% of Ontario drivers who purchase underinsured coverage (now SEF 44), are in some respects purchasing first party protection for both economic and non-economic (pain, suffering, etc.) loss.

I can see no valid reason why the provision of humane no fault benefits and tort law cannot co-exist. As a matter of general principle if all those injured in motor vehicle accidents are entitled to humanely structured no

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[60] Conference, Toronto, May 15, 1987.

fault benefits and access to universal social programs, I see little justification for abolishing or restricting recourse to tort law. The preservation of fault-based access to individualized compensation accords with the public's sense of what is right and in a modest way may achieve some deterrence benefits. The criticism of the tort system on compensation grounds is answered by the availability of fair and comprehensive no fault benefits. In the final analysis, the legitimacy of the co-existence of no fault and tort depends upon two considerations. First, there must be a substantial expansion in the quantum of no fault benefits and in the eligibility criteria for these benefits. Second, the compensation plan must be capable of being delivered through the automobile insurance system at a reasonable cost.

No fault benefits for those injured in motor vehicle a idents, are, in my view essential. If no fault benefits are increased, as I think they must be, first party premiums will have to go up. The increase will be modified by the existing third party offset which I think should continue. No fault benefits paid or available should continue to be deducted from a third party judgment or settlement. The cost savings resulting from the recommendations contained in Chapter 10 will be discussed in more detail later. For now, I note that all of these savings should more than cover any increase in first party costs attendant upon the implementation of the no fault benefits that I propose be made part of the standard form of automobile insurance policy. Although changes in pre-judgment interest, the collateral source rule, etc., are cost justified, they are also justified on compensation principles generally. Finally, cost savings will result from the implementation of the Ontario Court's Inquiry

recommendation as to the Provincial Court (Civil Division). I note as well that substantial additional cost savings would result if insurers were to impose a more realistic rough upper limit on party-and-party costs now paid to claimants' counsel. The private sector could benefit from the experience of the public insurers in Manitoba, Saskatchewan and British Columbia in that regard. All three public insurers pay substantially less in party-and-party costs than is the case in Ontario.

H. NO FAULT BENEFITS (ACCIDENT BENEFITS): RECOMMENDATIONS

(a) Eligibility

There should be no conduct-related exclusions to no fault benefit entitlement. The no fault benefit package should be truly no fault. All those injured in motor vehicle accidents (including pedestrians) should be given access to the no fault benefits.

Accordingly, the standard form of automobile insurance policy should be expanded to provide no fault accident benefits without exclusions related to driving conduct.

(b) Rehabilitation/Medical

I endorse the emphasis which has in the recent past been placed on rehabilitation. The I.B.C. proposal and the Ontario Task Force on Insurance Report both recommended a substantial increase to the existing Section B rehabilitation benefit. It seems to me that it would be inappropriate to make the benefit unlimited. Regulatory

problems mitigate against that. The rehabilitation benefit should, however, have a generous limit in both quantum and time.

I recommend that the rehabilitation benefit be increased from $25,000 to $500,000 per claim. The time limit should be increased from 4 years to 10 years, or 20 years less the victim's age, whichever is longer. The $500,000 limit will be sufficient for all but the most unusual and catastrophic of cases. The time limitation is designed to provide a minimum period of 10 years access to rehabilitation. The 20 years less the victim's age provision is designed to catch children who are injured and who require rehabilitation over an extended period of time. Head injuries, particularly involving children, often require extended rehabilitation.

Rehabilitation should be expansively yet clearly defined so as to remove doubt as to the first party insurer's obligation to fund physical and vocational rehabilitation. One structurally sound definition of rehabilitation can be found in the United Nations publication World Program of Action Concerning Disabled Persons:

> Rehabilitation means a goal-oriented and time-limited process aimed at enabling an impaired person to reach an optimum mental, physical and/or social functional level, thus providing her or him with the tools to change her or his own life. It can involve measures intended to compensate for loss of function or a functional limitation (for example, by technical aids) and other measures intended to facilitate social adjustment or readjustment... Rehabilitation usually includes the following type of services: (a) early detection, diagnosis and intervention;

> (b) medical care and treatment; (c) social, psychological and other types of counselling and assistance; (d) training in self-care activities, including mobility, communication and daily living skills, with special provisions as needed, e.g. for the hearing impaired, the visually impaired and the mentally retarded; (e) a provision of technical and mobility aids and other devices; (f) specialized education services; (g) vocational rehabilitation services (including vocational guidance) vocational training placement in open or sheltered employment; (h) follow-up... In all rehabilitation efforts, emphasis should be placed on the abilities of the individual, whose integrity and dignity must be respected. The normal development and maturation process of disabled children should be given maximum attention. The capacities of the disabled adults to perform work in other activities should be utilized.[61]

Rehabilitation should be paid for at the first party level, not on an expense incurred only basis, but rather by giving the claimant, the claimant's medical advisors and the claimant's medical rehabilitation counsellors the benefit of the doubt. If the first party insurer requires an independent medical examination, it should, of course, be entitled to one. In the meantime, rehabilitation should be undertaken and paid for, not delayed or denied completely.

Giving the benefit of the doubt to the injured person may be new to automobile insurance. It is not, however, all that unusual. Both the federal Pension Act[62] and the

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[61] United Nations Decade of Disabled Persons, 1983 to 1992: World Program of Action Concerning Disabled Persons, pp. 3 and 5.

[62] R.S.C. 1970, c. P-7 as amended. See section 85.

Ontario Workers' Compensation Act[63] contain benefit of the doubt provisions enuring to the benefit of the injured person. By way of illustration, section 3(4) of the Workers' Compensation Act provides:

> In determining any claim under this Act, the decision shall be made in accordance with the real merits and justice of the case and where it is not practicable to determine an issue because the evidence for or against the issue is approximately equal in weight, the issue shall be resolved in favour of the claimant.

Medical expenses should continue to be in excess to O.H.I.P. For all practical purposes, O.H.I.P. absorbs all medical, hospital-related expenses.

(c) Long-Term Care

Long-term care should be separated from rehabilitation and fixed at $500,000. The family of the injured person should not be excluded from long-term care compensation entitlement. Reasonable family participation in long-term care should not be discouraged, but rather encouraged. The long-term care benefits should be paid to the injured person so as to permit the injured person as much freedom of movement as can be built into the system. Long-term care benefits should be no greater than the monthly cost of group residence which might reasonably accommodate the insured's needs having in mind the nature of the injuries and any other relevant factors.

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[63] R.S.O. 1980, c. 539 as amended by S.O. 1984 c. 58, s. 3.

(d) Disability Benefits

The quantum of the income replacement benefit must be increased to provide economic stability for those injured in motor vehicle accidents. It is, however, inappropriate in my view to establish an inordinately high income replacement benefit. It must be remembered that it is compulsory for Ontario's drivers to buy this coverage. Many drivers will not be able to resort to it. For example, the unemployed (including the retired) will often have no access to the no fault income replacement benefit if injured, yet those persons are compelled to purchase the coverage. Nonetheless, I have concluded that the coverage must continue to be compulsory. It is in the public interest that a safety net be established at the first party level for all Ontario drivers. For those who will not have access to the income replacement benefit, subsidization of others through Section B automobile insurance premiums will be relatively modest. High income earners will as well tend to have limited or no access to the first party benefits because of income continuation plans. They too will be required to modestly subsidize others in the system through their Section B automobile insurance premiums. I see no problem with that.

(i) The Employed

The no fault benefits should include an income replacement benefit based upon 80% of the claimant's gross income up to a maximum of $450 a week. The $450 a week disability benefit is reasonably consistent with the existing Workers' Compensation

benefit.[64] It is, in my view, desirable that a special group, those injured in motor vehicle accidents, should not have access to a no fault benefit significantly higher or lower than the benefit available to those injured in the workplace. I recognize that motor vehicle accident victims, unlike those injured in the workplace, have access to the tort system. However, because of the emphasis I place on the no fault package I am of the view that these disability benefits should be similar. Further, if we eventually proceed to a comprehensive accident (or disability) compensation scheme, compensation rights for all those injured (or disabled) will merge. In the meantime, we cannot stand still. Based upon Inquiry Claims Survey data, a disability benefit of $450 per week will result in 95% of wage earners receiving at least 80% of their gross wages from the automobile policy or from employer benefits.

I have opted for a gross, as opposed to a net, income calculation for accident benefits. It is simpler and follows the system we have used since 1969. Overcompensation will be rare using an 80% gross wage calculation. Using a net income base for calculation purposes requires estimating the claimant's tax rate and taking into account the impact of income tax on any taxable collateral source receipts.

Except for U.I.C. benefits, disability benefits should be non-primary. Making disability benefits primary to U.I.C. benefits will add very little to the disability

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[64] W.C.B. disability benefits are indexed. The current benefit is 90% of net income to a maximum gross income of $35,100 per year.

benefit cost and will resolve a major delivery problem. Some insurers are now routinely deducting U.I.C. sickness/accident benefits for disability benefit calculation purposes; other insurers instruct insureds to apply for U.I.C. sickness/accident benefits. This inevitably results in delay and an erosion of the availability of the U.I.C. benefit should the insured become eligible for it. Some insurers arbitrarily calculate the claimant's U.I.C. benefit entitlement and deduct it whether or not the claimant has seen fit to seek the benefit.

Disability benefits should not be paid for the first seven days. This will eliminate very short-term injuries from the system. It will also reduce transaction costs for those short-term cases in which transaction costs are now as much as the benefit that is eventually paid. A seven-day deductible will eliminate the incentive to stay off work now built into the system because of the first day payment of benefits and the non-deduction of collateral source payments in the first two weeks following disability. One of the basic problems of the present system is that it de-emphasizes rehabilitation; paying admittedly meager benefits from day one without collateral source offset, emphasizes the benefits of not working. The seven-day deductible policy is consistent with Quebec's no fault plan and the add on plans in all other provinces.

An insured should be entitled to disability benefits beyond age 65. I view this to be an equity rather than a constitutional issue. Because retirement is common at age 65, pension benefits received by the insured at that age (including RRSP, pension receipts) should be offset. I

recognize that those injured shortly before retirement age will benefit from this proposal. I am, however, more concerned about those injured at an earlier age who will have had their capacity to develop a worthwhile pension destroyed. For that group, it would be an injustice to terminate disability benefits at age 65.

(ii) The Deemed to be Employed

Some provision has to be made for those who are not employed, but who are denied access to employment because of motor vehicle accident-related injuries. At present an injured insured over 18 and under 65 is entitled to disability benefits if the injured insured has worked six months out of the previous twelve. Any eligibility criterion is bound to be arbitrary. Cost considerations and what seems to me to be the absurdity of providing an income benefit to the chronically unemployed suggest the six month out of twelve provision is reasonable.

While I agree generally with the concept of paying disability benefits to the deemed to be employed, I think certain changes have to be made as to their eligibility for these benefits:

(a) Eligibility should commence at age 16, not age 18. An insured can drive at age 16. I see no basis in principle for discriminating against 16 and 17-year-olds. Moreover, such discrimination may well offend section 15 of the Charter and not be saved by section 1. There is a basis in principle for limiting eligibility at age 65 for

those persons not having actual employment, but rather deemed to be employed.[65]

(b) The deemed to be employed benefit should be subject to a 60-day waiting period. It seems to me to make no sense to pay an income replacement benefit to a person who has by definition lost no short-term income. The deemed to be employed are, of course, different from the employed. They have no employment and no contract of employment. It seems to me to make sense to impose a realistic deductible in those circumstances. Scarce resources should be conserved for the more seriously injured. This proposal is consistent with what is soon to take place in Quebec where the Régie benefits are about to be changed in order to impose a six-month waiting period for the unemployed. The Régie legitimately expects to reduce both claims and transaction costs in this way. Ironically, one of the reasons for the recent Quebec cost concern is the proposal to make substantially increased non-pecuniary compensation available (on a no fault basis) to Quebec motor vehicle accident victims.

Once eligible for the disability benefit an insured deemed to be employed should be entitled to the same benefit as the employed. It must be noted that an insured who is unemployed, but who has a contract of employment, should receive disability benefits when exposed to income

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[65] See the discussion in Chapter 14.

loss whether or not he has worked six months of the previous twelve.

(iii) Students

Students should be eligible for no fault compensation. The loss of the school year has an obvious economic value. Younger students, if seriously injured, will have lost the capacity to earn income and perhaps even to receive a full education. The 16 to 20-year-old driving group is most vulnerable. Sixteen to 20-year-old males, in particular, have high accident frequency and severity records. A 16-year-old student is by law authorized to drive. Younger students will most likely have a third party action against one or more at-fault drivers through which the student can obtain compensation. There may, of course, be student pedestrians who because of fault have no valid third party claim.

Students should receive no fault compensation as follows:

(a) If an injured student is in elementary school and loses a school year as a result of motor vehicle accident injuries, the student should receive $1,000 for each school year lost.

(b) If the injured student is in secondary school, the student should receive $2,000 for each school year lost.

(c) If the injured student is in college or university, the student should receive $4,000 for each year of eduction lost to a maximum of three

years, or if a semester is lost, the appropriate part of $4,000 according to the university's semester system.

(d) Injured elementary and secondary school students should be entitled to $340 per week (approximately 80% of the average industrial wage) at age 19 if disabled and not attending school. An injured college or university student, if disabled, should receive $340 a week when the injured student is no longer entitled to the loss of school year benefits.

(e) Death Benefits

The no fault part of the standard automobile insurance policy should contain a death benefit. The death benefit should not be linked to the deceased's income, but should rather provide some reasonable short-term financial assistance to survivors, responsive to the simple recognition of the value of life. The death benefit should be modest but not insignificant. An inordinately low death benefit will trivialize the value of life; an inordinately high death benefit on the other hand, even if unrelated to income, will provide compensation for those who have little or no need for it (especially if life insurance is not deducted). Moreover, consumers should not be forced to purchase protection which is in the nature of life insurance beyond an amount which gives tangible recognition to the value of life. For those who require the additional protection generally provided by life insurance that protection should be purchased on a voluntary basis through the life insurance markets, or as part of optional coverage under the automobile policy.

Having in mind the above considerations, in my view, the death benefit should be $25,000 for the death of the head of the household or the death of the spouse of the head of the household. An additional $10,000 should be paid for each dependant of the head of the household or spouse. If a dependant child is killed, the death benefit would be $10,000.

(f) Funeral Benefits (Burial)

The funeral benefit is too low and should be increased to $3,000. The cost of this benefit is not significant and will accommodate reasonable funeral and burial expenses.

(g) Home Care and Child Care

Homemakers should be treated more generously and the benefit should be differently structured. I propose to subdivide the benefit to provide separate benefits for housekeeping assistance and child care. Child care will include dependants' care. For anyone who is injured in an automobile accident having responsibility to care for children, urgency in the true sense of that word arises. Child care must, in my view, be taken into separate account in structuring a responsible homemaker's benefit. Children who require the care of a hospitalized mother cannot be expected to wait. Immediate no fault compensation must therefore be made available.

As I stated earlier, the present $70 per week housekeeper benefit, limited as it is to 12 weeks, is too low in all respects and more importantly is conceptually flawed. Further, the same standard of disability should

be used as for wage earners, to trigger home care/child care no fault compensation entitlement.

(i) Home Care

This benefit should be $50 per week maximum payable on a reasonable expense-incurred basis. There should be a 7-day waiting period. The standard of disability should be the same as for regular disability benefits. The requirement that a person (usually a woman) who is engaged in home care has to be totally incapacitated before being entitled to this benefit is singularly inappropriate. This benefit is designed to look after household expense: preparation of meals, housekeeping, snow shoveling, grass cutting, etc.

(ii) Child Care

This benefit will acknowledge the need for immediate compensation for those responsible for children (or adults who happen to be legitimately dependant). When a person having responsibility for child care in particular is injured, the system must respond quickly. For this benefit, there should be no waiting period. The child care benefit should be $200 per week. An additional $50 per child or dependant per week should be payable, to a maximum of $350 per week. The benefit should be paid for two weeks without presentation of receipts and thereafter in response to reasonable and proven expenses to the above maximum. There should be no family member exclusion. As in the case of the home care benefit, the standard of disability should be the same as for regular disability benefits.

I. SUMMARY OF RECOMMENDED SYSTEM

Third Party Liability (Bodily Injury and Property Damage)	Minimum Coverage: $200,000
Rehabilitation	$500,000 per claim Time limit: 10 years or 20 years less victim's age, whichever is longer
Long-Term Care	$500,000 per claim Family members included in compensation entitlement. Benefits not to exceed the monthly cost of group residence which might reasonably accommodate victim's needs, having in mind nature of injuries and other relevant factors.
Disability Income Benefits	
1) Employed	80% of gross income, to maximum of $450 per week. Primary to U.I.C. only; non-primary to other benefits. Must be 16 or over. 7-day waiting period.
2) Deemed to be Employed	Must have worked 6 months out of previous 12. 80% of gross income, to maximum of $450 per week. Must be between 18 and 65. 60-day waiting period.
3) Students	Elementary school: $1,000 for loss of year; $340 per week at age 19 if disabled and not attending school Secondary school: $2,000 for loss of year; $340 per week at age 19 if disabled and not attending school College/university: $4,000 for loss of year: $340 per week when no longer entitled to loss of school year benefits

Child Care	$200 per week with additional $50 per week per dependant or child to maximum $350 per week. No waiting period. Payable for 2 weeks without proof of expenses incurred; payable after 2 weeks with proof of reasonable expenses incurred.
Home Care	$50 per week maximum, payable on basis of reasonable expenses incurred
Death	Death any time after accident Head of household or spouse of head of household: $25,000 Each dependant: $10,000 Dependant child: $10,000
Funeral	$3,000

All benefits except the death benefit indexed once a year to annual consumer price index, subject to a maximum of twice the stipulated benefit.

J. COST

I have made it clear throughout that I regard the cost and premium consequences of any proposed compensation plan to be crucial. We have too often embarked upon a search for a compensation utopia without paying any regard to cost. While cost issues may not be determinative, cost is nevertheless important. Consumers are entitled to know what a proposed compensation plan will cost, and what premiums can reasonably be expected if a proposed compensation plan were to be implemented.[66]

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[66] For a full discussion and analysis of the changes in loss costs resulting from my proposed changes in accident benefits and my recommendations on compensation issues (Chapter 10) see Appendix III.

(a) Private Passenger Cars

For private passenger automobiles, in the compensation system I have proposed, the cost breakdown per car and the change up or down from the current system is set out in Table 12.1.

Table 12.1 shows cost changes on a per car basis. This seems to me to be the clearest way to demonstrate cost changes. As can be seen from the Table 12.1, the proposed changes result in a cost reduction of $12.52 per car. In the end result, if my recommendations are accepted, Ontario's motorists will be the beneficiaries of substantially increased no fault benefits at moderately reduced cost and without the collateral sacrifice of any right to individual compensation under tort law. Total cost savings should be approximately $65 million. Premium decreases should at least equal the cost savings.

To the extent that premium reductions result there will be a further cost reduction in that premium tax and commissions, both of which are directly linked to premiums, will be reduced. It should also be noted that the estimated cost reduction will have a ripple effect which has not been taken into account in the calculation set out in Table 12.1. Any change which goes to reduce the quantum of third party claims costs will have an effect on prejudgment interest and party-and-party costs. For example, if the changes to prejudgment interest are implemented, claims costs will go down.[67] When that

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[67] It should also be noted that the cost estimate in Table 12.1 assumes the current statutory prejudgment interest rate, ie. the bank rate plus 1%. If, as I have

TABLE 12.1

PRIVATE PASSENGER CARS LOSS COST

	Current	Proposed	Change[68]
No Fault Benefits			
Rehabilitation/Long-Term Care/Medical	7.72	18.56	10.84
Funeral	0.22	0.88	0.66
Death	1.20	3.47	2.27
Disability - wage earner	13.57	30.94	17.37
- student	nil	2.58	2.58
- homecare	incl	0.16	0.16
- childcare	nil	2.29	2.29
Total No Fault Benefits	22.71	58.88	36.17
Third Party Liability			
Bodily Injury (Claims Only)	198.64	173.67	(24.97)
Bodily Injury Adj. Expense	29.68	29.68	nil
Total 3rd Party Liability	228.32	203.35	(24.97)
Compensation Issues			
Abolishing collateral source rule	na	(6.62)	(6.62)
Prejudgment interest	na	(9.14)	(9.14)
Party-and-party costs re Provincial Court	na	(5.76)	(5.76)
Total Compensation Issues	na	(21.52)	(21.52)
Other			
Property Damage Loss Costs	78.76	78.76	nil
Quebec Part III	0.92	0.46	(0.46)
Uninsured Motorist	8.55	6.81	(1.74)
Total Other	88.23	86.03	(2.20)
TOTAL LOSS COSTS	339.26	326.74	(12.52)

recommended, the prejudgment interest rate is lowered to the bank rate, further savings will result. Costing of the funeral benefit was based on a benefit of $4,000. I have recommended a $3,000 funeral benefit. The cost difference is insignificant.

[68] The figures in brackets indicate a cost saving.

occurs, party-and-party costs will be reduced. Similarly, if the collateral source rule were abolished, both prejudgment interest and party-and-party costs would be reduced. Gross-up (structured settlements) has not been included in the cost calculation because of an absence of data supporting cost conclusions in that area. If, however, the structured settlement recommendations made in Chapter 10 were to be implemented, further cost reductions would accrue. The cost figures for the proposed compensation plan are estimates which are actuarially sound, but which are still estimates. I am satisfied, nonetheless, that the cost changes closely approximate what might realistically be expected to result should my proposals be adopted. In addition, the suggested changes in legislation dealing with prejudgment interest, gross-up and the collateral source rule if applied generally will result in substantial savings in areas outside of automobile insurance.

As can be seen from Table 12.1, increasing the first party no fault benefits as I have proposed results in a decrease in third party liability costs of $24.97 per car. This, of course, is because of the requirement that first party benefits received be deducted from any third party claim. Increasing first party benefits, therefore, reduces an insurer's third party obligation. As can be seen, the reduction is substantial. Moreover, the no fault benefit plan I have proposed should work to limit the number of cases entering the third party system in the first place in that in smaller cases the increased no fault benefits will make it less likely an injured person will feel required to sue to secure compensation. The

right to sue has been preserved. The need to sue has been reduced.

There is a further compensation issue which I have not addressed in the proposals I have made, but which nevertheless should be considered. I refer to the calculation of income loss. The Inquiry Claims Survey indicates that loss of income to settlement or trial accounts for 13 cents out of every claims dollar and that future loss of income accounts for 10 cents out of every claims dollar.[69] The calculation of both past and future loss of income is made on a pre-tax basis, but the lump sum payment received is not taxable because the compensable loss is viewed as a capital loss (loss of capacity to earn income).[70] This capital loss is consistently measured by the claimant's actual pre-tax loss of income. This leads to overcompensation for income loss.

In the first place, particularly for past income losses, it seems to me the capital loss approach is a fiction and should be discarded for the purposes of the direct calculation of loss of income. If the plaintiff has sustained a loss of employment advantage, that is a capital loss and the plaintiff should be compensated for it. Second, even if past loss of income is to be viewed as a capital loss, it seems to me to be inappropriate to measure the loss on a pre-tax basis. The case for treating future income loss as a capital loss is perhaps more plausible. Once again, however, it seems to me a

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[69] See Figure 7.7.

[70] See The Queen v. Jennings, [1966] S.C.R. 543.

convincing case can be made for valuing that future loss (even if considered as a capital loss) on an after-tax basis. I recognize that if this is done the future income loss must be grossed up. That is exactly what happens in fatal accident cases where a dependant's pecuniary loss is assessed on an after-tax basis. Even if we continue to treat future income loss on a pre-tax basis, there is justification in treating past income loss on an after-tax basis.

If loss of past income were dealt with on an after-tax basis, Inquiry Claims Survey data suggest cost savings would be about $6 per car. If future income loss were dealt with on an after-tax basis, there would be further cost savings of about $4 per car. In addition, if all income loss were assessed on an after-tax basis, the abolition of the collateral source rule would result in approximately $13 savings per car, that is $7 per car more than reflected in Table 12.1. If all of these adjustments were made there would be additional cost savings of approximately $85 million.

(b) Motorcycles

As was indicated earlier, motorcycles present a cost/premium problem in any enhanced no fault benefit environment. Motorcycles cause relatively little damage. Motorcycle drivers and passengers are, however, relatively unprotected and hence vulnerable to serious injury in the event of an accident. It follows that motorcycles represent an increased first party no fault risk and a decreased third party risk compared to private passenger automobiles and more so trucks.

Table 12.2 sets out the motorcycle costs with and without subrogation. The changes I have proposed result in a cost increase for motorcycles at the first party no fault level of approximately $103 per motorcycle. $75 of this comes from the disability benefits proposed. The cost increase attributable to medical rehabilitation and long-term care is approximately $24. It is noteworthy that the cost increase attributable to home care and child care for motorcycles is modest, being approximately 60 cents. Inquiry Claims Survey data suggest that homemakers and those responsible for child care are not frequently found on motorcycles. In any event, after adjustments have been made on the third party side, without subrogation, motorcycles would be exposed to a premium increase of approximately $85 per motorcycle. With subrogation, the cost/premium increase will be about $31. Because the expanded no fault benefits will provide a relatively severe premium problem for motorcycles, subrogation for motorcycles should be permitted.

(c) Commercial Vehicles (Ordinary Trucks)

In the system I propose, trucks will be exposed to somewhat lower premiums. Because "trucks" encompasses a great variety of vehicles, it is difficult to be precise in estimating specific premium changes.

Table 12.3 sets out commercial vehicle costs in the system I propose. Special risks are not included. The recommended increase in no fault benefits will result in a smaller premium increase for trucks than for private passenger automobiles. The Workers' Compensation system will absorb much of the economic loss caused to truck

TABLE 12.2

MOTORCYCLES LOSS COST

	Current	w/o subrogation Proposed	Change	w/subrogation Proposed	Change
No Fault Benefits					
Rehabilitation/Long-Term Care/Medical	17.06	40.94	23.88		
Funeral	1.06	4.24	3.18		
Death	2.49	7.20	4.71		
Disability- wage earner	41.89	95.51	53.62		
- student	nil	21.36	21.36		
- homecare	incl.	0.04	0.04		
- childcare	nil	0.57	0.57		
Total no fault benefits	62.50	169.86	107.36	85.34	21.23
Third Party Liability					
Bodily injury (Claims only)	74.40	64.73	(9.67)	93.74	19.34
BI claim adj. expense	11.12	11.12	nil	13.90	2.78
Total 3rd Party Liability	85.52	75.85	(9.67)	107.64	22.12
Compensation Issues					
Abolishing collateral source rule	na	(2.59)	(2.59)	(2.59)	(2.59)
Prejudgment interest	na	(3.42)	(3.42)	(3.42)	(3.42)
Party-and-party costs re: Provincial Court	na	(2.16)	(2.16)	(2.16)	(2.16)
Total Compensation Issues	na	(8.17)	(8.17)	(8.17)	(8.17)
Other					
Property Damage Loss Cost	17.21	17.21	nil	17.21	nil
Quebec Part III	1.61	0.81	(0.80)		
Uninsured Motorist	18.74	14.83	(3.91)	14.83	(3.91)
Total Other	37.56	32.85	(4.71)	32.04	(3.91)
TOTAL LOSS COSTS	185.58	270.39	84.81	216.85	31.27

TABLE 12.3

COMMERCIAL VEHICLES (Ordinary Trucks)

	Current	Proposed	Change
No Fault Benefits			
Rehabilitation/Long-Term Care/Medical	2.87	6.89	4.02
Funeral	0.14	0.56	0.42
Death	0.94	2.72	1.78
Disability - wage earner	6.55	14.93	8.38
- student	nil	1.24	1.24
- homecare	incl.	0.06	0.06
- childcare	nil	0.92	0.92
Total No Fault Benefits	10.50	27.32	16.82
Third Party Liability			
Bodily injury (Claims Only)	213.41	195.15	(18.26)
BI claim adj. expense	31.89	31.89	nil
Total Third Party Liability	245.30	227.04	(18.26)
Compensation Issues			
Abolishing collateral source rule	na	(5.65)	(5.65)
Prejudgment interest	na	(9.82)	(9.82)
Party-and-party costs re: Provincial Court	na	(6.19)	(6.19)
Total Compensation Issue	na	(21.66)	(21.66)
Other			
Property Damage Loss Cost	113.30	113.30	nil
Quebec Part III	0.64	0.32	(0.32)
Uninsured Motorist	2.86	2.39	(0.47)
Total Other	116.80	116.01	(0.94)
TOTAL LOSS COSTS	372.60	348.71	(23.89)

drivers as a result of motor vehicle accidents. In addition, on balance, the occupants of trucks are less likely to be injured than the occupants of private

passenger automobiles. Table 12.3 shows savings of about $24 per vehicle.

K. OTHER CONSIDERATIONS

All accident benefits other than the death benefit should be indexed. It is important that some form of indexation be applied. The indexation I suggest to take the reality of inflation into account is the annual consumer price index subject to a maximum of two times the stipulated benefit. For example, this would permit the proposed disability benefit to expand with the consumer price index deemed inflation rate to a maximum of two times the existing benefit or $900. If inflation over a period of time increased the disability benefit to $900, the increase would then stop. The benefit should then be revisited. The indexation process should be applied once a year. As matters now stand, I would suggest July 1 of each year because it accords with the insurers' year for statistical purposes.

There will be some injured claimants who will receive at least 80% of their gross wage loss from collateral sources (employer benefits). Those claimants will not be entitled to disability benefits under this proposal. If the employer benefits are not indexed, as is often the case, inflation will result in an injured claimant with collateral benefits being worse off than an injured claimant without collateral benefits. The injured claimant without collateral benefits will be entitled to receive indexed disability benefits under this proposal. In the circumstances, those claimants placed in a position of relative disadvantage because of the indexation provisions of this proposal should receive an incremental

benefit after two years of disability, the purpose of which is to bring claimants who have no access to indexed disability benefits and those who do have that access into a position of equality.

Accident benefits claims forms should be common to all licensed insurers. The forms should be simplified and colour coded so that one form is not confused with another. It is necessary to continue to use three forms: the claimant's form, the employer's form and the medical form.

Those in hospital for more than seven days should be paid the first two weeks of accident benefits entitlement without a medical report, unless there are circumstances which clearly and unequivocally suggest that payment is inappropriate.

Adjusters (both company and independent) should be given a specific disability benefit authority so that injured insureds receive their contractual entitlement quickly. I suggest a $2,000 authority.

I recommend that claimants pay for the cost of obtaining reasonably required disability benefit medical report forms for the first three months of disability and thereafter the cost of these short medical reports should be borne by the insurer. I further recommend that insurers and the medical profession try to reach agreement on an acceptable fair fee for these medical reports. Alternatively, a reasonable fee could be built into the O.H.I.P. schedule and processed as a regular part of the doctor's O.H.I.P. billings. If a new agreement were reached with O.H.I.P. to replace the 1978 Agreement, the

very minor cost attendant upon including this tariff item could be taken into account.

Section B forms should be forthwith delivered to the injured insured if the insured is in hospital, and mailed or delivered to the insured if the insured is not in hospital. The onus of delivery of the required forms should be on the insurer. My preference is that hospitals be given a supply of medical forms (and if practicable the other forms as well) so that those forms could be routinely completed at the earliest possible date. Emergency doctors would then be able to complete the medical forms in those cases where hospital treatment is accorded the injured insured but the insured is released.

An attempt should be made to co-ordinate the automobile insurance no fault forms with those of Workers' Compensation, U.I.C., Canada Pension Plan and long-term disability carriers. In a perfect world, all would be using the same forms.

To avoid problems with a physician's authority to complete the medical form, the Insurance Act should be amended to provide the insured's physician (or as I have recommended in Chapter 5, the insured's treating chiropractor) with the required authority to complete the form and remit it to the insured's insurer. Alternatively, the medical form could be so constructed as to contain the required authorization. In that event, the medical form would have to be signed by the insured.

I hope we are not too far from having an insured's disability benefit entitlement (as well as the insured's entitlement to other no fault benefits) paid to the

insured automatically by the insurer through computers. The fewer human hands involved in these first party dealings the better. There is, of course, a need to have a direct initial personal contact between the injured insured and a representative of the insurer.

The calculation of the disability benefit should be made available to the insured so that the insured or anyone to whom the insured goes for assistance can determine how the net disability benefit paid to the insured has been established.

Return to work, full or part-time, should be encouraged. An insured should not become disentitled to disability benefits by returning to work. The 30-day return to work provision contained in the automobile policy should be increased to 90 days.

Finally, disability benefits must be paid promptly. Those benefits should be paid within 15 days of the insurer's receipt of the required forms. I will deal later with unfair claims practices. For now, I note that unreasonable delay in the payment of accident benefits should be deemed to be an unfair claims practice.

L. ALTERNATIVE COMPENSATION PROPOSAL

The Order-in-Council establishing this Inquiry requires that I consider the appropriate design of a no fault compensation plan for Ontario. In the plan I have proposed, the right to seek individual compensation has not been eliminated or limited. Although the no fault benefits have been substantially expanded, it might be

said that the proposed compensation plan cannot reasonably be characterized as a no fault plan.

As is evident, I have rejected both pure no fault and threshold no fault plans. It can thus be said that I do not regard pure no fault or threshold no fault (in their commonly understood forms) as appropriate. There is, however, a modified threshold no fault plan which I think is worthy of consideration.

The plan I have in mind involves a threshold-based capping of non-pecuniary general damages in less serious cases. In threshold no fault proposals, looked at generally, less serious cases are removed from the system with the result that any person suffering a non-serious injury (depending on the threshold definition) receives no non-pecuniary general damage compensation. For the most part, those proposing threshold no fault have done so on a cost basis. This was discussed earlier in this chapter. As also discussed earlier, one of the serious disadvantages of threshold no fault plans, such as the I.B.C. plan, is that they exclude more than the so-called less serious cases.

On any reasonable cost benefit analysis truly small cases do not fare well in the tort system. A fair threshold should focus on cases that legitimately involve injury and disability of a minor nature. Rather than denying the less seriously injured any compensation for pain, suffering and loss of enjoyment of life, it seems to me to make sense both from the standpoint of general principle and cost, to limit or cap the entitlement to non-pecuniary general damages of the less seriously injured.

My alternative recommendation is that non-pecuniary general damages in less serious cases (as defined by a moderate verbal threshold) should be capped with the result that in those less serious cases which do not meet the defined threshold, non-pecuniary general damages will be limited to a pre-determined maximum. My suggestion is that the maximum be in the area of $3,000. In that way, the threshold will not disqualify those not meeting it from access to non-pecuniary compensation, but will rather impose an upper limit on the amount of that compensation. A claim falling below the threshold which is so modest in its proportion as to not entitle a claimant to $3,000 would, of course, attract an assessment of non-pecuniary general damages of less than $3,000. A claim now worth more than $3,000 for non-economic loss which did not meet the threshold would be capped at $3,000.

The number of claimants that might be affected by this proposal is difficult to determine. A substantial number of claims are now disposed of for less than $3,000 in non-pecuniary compensation. Obviously, those cases would be unaffected by this proposal. The threshold definition would, of course, dictate the extent to which cases above $3,000 would be affected by a low end non-pecuniary general damage cap. If fatal accidents, serious cosmetic injuries and serious internal injuries, fractures of weight-bearing joints and the skull, etc., were left in the system as being demonstrably serious, the threshold I

have considered would result in a cost savings of about $24 per car.[71]

This approach is preferable to a blanket deductible that some have suggested would resolve cost/premium problems. In the deductible proposal, all non-pecuniary general damages would be subject to a specific blanket deductible. If, for example, the deductible were $5,000, anyone entitled to non-pecuniary general damages of $5,000 or less would recover nothing. A claimant entitled to $12,000 in non-pecuniary general damages would recover $7,000. It seems to me that cost savings under this proposal might well turn out to be somewhat illusory. General damages would increase because of the existence of the deductible. The deductible would become an inverse target. Further, imposing an arbitrary deductible, if applied to all injured claimants, would act as a tax on the system which would reduce non-economic loss entitlement even for the very seriously injured. If the very seriously injured were somehow to be excluded from the application of the deductible, further transaction costs would be built into the system as a result of having to determine those claimants who were subject to the deductible, and those who were not.

The threshold plan I have considered is subject to many of the same criticisms which I discussed in dealing with threshold no fault generally. In particular, whatever language is used to define the threshold and however carefully it is drafted, transaction costs in

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[71] This estimate was provided by Joe Cheng based upon Inquiry Claims Survey data.

applying it will not be insignificant. I recognize that the net cost benefits may well be small. For that reason, this proposal is not one that I endorse as a primary recommendation.

CHAPTER 13

OTHER INSURANCE AND CONSUMER ISSUES

A. CATASTROPHIC CLAIMS FUND

A catastrophic claims fund is a means by which an insurer's first party losses in excess of a stipulated sum are pooled on an industry-wide basis. Such claims funds have been established in Michigan and New Jersey; both states have unlimited medical/rehabilitation first party benefits.

In both Michigan and New Jersey, it is clear that the rationale underlying the creation of a catastrophic claims fund is the perceived need to reduce the potential impact, particularly on small insurers, of an unlimited liability for medical/rehabilitation expenses. The Michigan Catastrophic Claims Fund is operated by the Michigan Catastrophic Claims Association. The Association indemnifies insurers for losses that are expected to exceed $250,000. The Michigan pooling mechanism is funded by a per car assessment.

In my view, there is no need to establish a catastrophic claims fund in Ontario. The no fault benefits proposed in Chapter 12 are all capped, that is to say none are open-ended. Medical expense in Ontario is absorbed by O.H.I.P.; long-term care is capped at $500,000 and represents a loss cost that will tend to be late blooming. Rehabilitation is capped at $500,000; it, however, tends to represent a front-end loaded cost exposure and hence may be a matter of concern for smaller insurers. Nevertheless, in my opinion, if insurers are

writing the coverage, they should be able to pay the claims without the crutch of loss pooling. Moreover, insurers needing additional protection can obtain it (at a cost) through reinsurance markets.

If Ontario were to introduce a catastrophic claims fund, the mechanism resorted to should operate through the Facility Association. A separate structure is not required.

B. CONSUMER INFORMATION

It is imperative that consumers have better access to relevant information about premiums, underwriting practices and claims procedures. Consumers should have an outlet for expressing complaints and concerns about these matters, quite apart from mechanisms established for dispute resolution.

Recommendations as to disclosure by brokers and the structure of the automobile insurance policy were made in Chapters 5 and 6 and I will not repeat what I said there except where necessary. As a matter of general principle, however, I note that those purchasing automobile insurance are entitled to know what they are buying and what they are paying for it. This will necessarily require complete disclosure of the premium breakdown including the broker's commission.

Premiums should be publicized and explained.[1] I do

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[1] See Chapter 16. If premiums are set by the proposed rate regulation legislation, publication of premiums set by the Board should be sufficient.

not suggest actuarial detail is required; nevertheless, insurance can at least partly be demystified by disclosure. The public is quite capable of understanding basic rating concepts such as territory, vehicle type, use of vehicle, etc.

Consumers should have access to claims information including:

(a) the insured's entitlement to no fault benefits and the quantum of those benefits;

(b) procedures to be followed in asserting third party claims;

(c) the availability of dispute resolution mechanisms;

(d) the availability of social programs which might be of relevance to a person injured in a motor vehicle accident;

(e) the consumer's right to challenge legal fees through the assessment process in those cases where an insured has retained a lawyer;

(f) particulars of any relevant limitation periods.

The provision of information to which consumers are entitled will require more than a hotline at the Ministry of Financial Institutions. It seems to me insurance matters, other than the rate review process, should be run through the office of the Superintendent of Insurance. The Superintendent's office will have to be expanded to accommodate the required dissemination of information. Consumers are entitled to effective advice and clear information. I am not suggesting that medical or legal advice be provided. That is the responsibility of doctors

and lawyers. Information should, however, be available to assist consumers in resolving medical and legal problems.

C. CLAIMS AND UNDERWRITING PRACTICES

It has become apparent to me that legislation is required to control what I view to be demonstrably unacceptable claims and underwriting practices. I do not envisage draconian restrictions and standards; nevertheless, some standards are required. Many American states have legislation establishing appropriate claims standards and providing penalties for violations. Minnesota's Unfair Claims Practices Act is a useful model.[2] The Minnesota Act imposes standards for claims handling, settlement offers, claims denial and responses to communications from the Office of the Commissioner of Insurance.

Some of the claims standards which should be the subject of regulation are:

(a) an injured insured should be provided with all required no fault documentation within 7 days of the accident; as stated in Chapter 12, all insurers should use the same no fault claims forms;

(b) no fault benefits should be paid within 15 days of the insurer's receipt of required documentation;

(c) no fault claims forms should include instructions as to processing the claim and the

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[2] Minnesota Statutes, 1982.

telephone number of a named insurance company representative who can assist the insured in processing the claim for first party benefits;

(d) if an insurer is reasonably required to continue investigating a claim beyond the 15-day period referred to above, where practicable the insurer should notify its insured of that fact and provide information as to the expected date when the investigation will be completed. When the investigation involves suspected fraud on the part of the insured, the insurer should not be required to disclose particulars of the investigation, except upon request to the office of the Superintendent of Insurance;

(e) if a claim is denied on the basis of a specific policy provision, condition or exclusion, the insurer should be required to give specific information as to the provision, condition or exclusion being relied upon;

(f) payment of any first party benefit should be accompanied by an explanation of what the payment is for. In the case of first party claims, the calculation of any disability benefit entitlement should be made available to the insured so that the insured will know how the disability benefit was determined;

(g) no insurer should be permitted to refuse to pay all or part of any first or third party claim where there is no reasonable good faith dispute as to the insured's or the claimant's entitlement;

(h) no insurer should require an insured or a claimant to sign a release extending beyond the subject matter giving rise to the claim payment;

(i) if a first party claim is denied on the basis of a medical opinion secured by the insurer, the insured should be given a copy of the medical report. Insurers should be prohibited from denying first party claims based on verbal medical reports;

(j) an insurer requiring a medical examination of an insured should be required to continue first party benefit payments pending the completion of the medical examination and the insurer's receipt of a medical report. The fact that any benefit has been paid by an insurer in those circumstances should not be taken as evidence against the insurer's position in the event of a dispute;

(k) it is important that the insurer's first party rehabilitation obligation not be ignored, as has too often happened in the past. Insurers should be obliged to fund reasonable rehabilitation if there is credible medical evidence, and in appropriate circumstances the evidence of a rehabilitation consultant, supporting the proposed rehabilitation. The insurer's obligation should crystalize then, not when the expense has been incurred. If an insurer wishes to resist a rehabilitation expense, it should clearly state the reasons for its position and if a medical opinion is being relied upon in support of the insurer's position, a copy of that report should be delivered promptly to the insured or the insured's solicitor. If an insured refuses to undertake or continue rehabilitation that has been recommended by his own medical advisor or the insurer's medical

advisor, the insurer's obligation to pay disability benefits should continue until the issue has been dealt with through the dispute resolution mechanism I propose;

(l) under the Minnesota Act, the Commissioner may "...adopt rules to ensure the prompt, fair and honest processing of claims and complaints." The Superintendent of Insurance should be given similar powers;

(m) insurers should face the prospect of reasonable financial penalties for unacceptable claims and underwriting practices. I would suggest $10,000 as the maximum penalty. The quantum of the penalty must be sufficient to impose a realistic sanction, but not so high as to make it unlikely the penalty would be resorted to. Hearings dealing with any alleged unfair claims or underwriting practice should be conducted by the Superintendent of Insurance or the Superintendent's nominee. The hearings should be relatively informal and subject to appeal only by way of judicial review;

(n) quite apart from penalties which may be imposed for an unfair claims practice, an insured who has received delayed or no payment of a first party benefit entitlement should be entitled to interest at twice the prime rate.

Underwriting abuses are more difficult to deal with in a definitive way, because of the variety of underwriting policies used by insurers. Submissions to this Inquiry have disclosed such a varied list of underwriting complaints that it is impossible to effectively catalogue them all. Some have been referred

to in previous chapters. At a general level, insurers should not be able to penalize insureds on the basis of intuition. There must be statistical or other evidence to justify underwriting decisions. The Superintendent of Insurance should have jurisdiction to respond to proved underwriting abuses and to impose appropriate penalties.

D. DISPUTE RESOLUTION

It is generally agreed that a better method of resolving first party disputes has to be found. In its Inquiry submission, the I.B.C. proposed a two-tiered dispute resolution mechanism.[3] At the first level, upon a denial of entitlement to any first party no fault benefit, an insured wishing to appeal or seek review must submit reasons for the insured's appeal to an I.B.C. review committee. The review committee would then attempt "...to resolve the difference of opinion with the ombudsman for the insurer". This set-up requires each insurer to appoint a senior claims representative to act as a no fault benefit ombudsman. The insurer's representative would be required to "...pre-authorize all denials or discontinuance of payments..." and as well the insurer's no fault benefit representative would be the contact person for review or appeal purposes. Any decision of the review committee would be binding only on the insurer. If any insured were dissatisfied with the insurer's review committee decision, the insured would be entitled to proceed to arbitration or sue.

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[3] I.B.C. Submission, p. 17.

The C.B.A.O. has attacked the I.B.C. dispute resolution proposal as potentially unfair and arbitrary. The C.B.A.O.'s main concern is the built-in conflict of interest, real or perceived, arising from the obligation placed by the I.B.C. on any insured to appeal to the insurance industry, a corporate part of which has denied the insured no fault benefits in the first place.

The main advantage of the I.B.C. proposal for review by an industry review committee is that the process should be both quick and cheap. It seems to me that if the insured is dissatisfied with the results, little will have been lost. I concede that there is validity to the perceived conflict of interest argument; however, the process is somewhat preliminary and may well work to eliminate some more obvious cases from the system quickly and inexpensively.

I question whether the insurer's no fault benefit representative (I have avoided use of the word "ombudsman") can be expected in practice to preauthorize all denials of no fault benefits. That seems to me in any event to be secondary to the requirement that every insurer designate one person as being responsible for review of no fault benefit payment decisions.

In the circumstances, as a first step to resolving disputes about accident benefits, I recommend acceptance of the I.B.C.'s review committee proposal. At that level, it is not necessary to deal with matters of onus; in the vast majority of cases, I would expect that review committee decisions could be made without requiring the insured's attendance. If that cannot be accomplished, the review committee could go to the insured, not the insured

to the review committee. I have in mind cases where an out of Toronto insured is involved in a no fault benefit dispute with an in-Toronto insurer. It must be emphasized that the review committee decision will be binding on the insurer. Otherwise, the system will not work. That is consistent with the I.B.C.'s dispute resolution mechanism submission.

I now move to consider what will happen if an insured having lost before the review committee wishes to proceed further. In my view, an insured should have access to arbitration or the courts by way of a de novo hearing. The decision of the review committee and its reasons should not be given any weight by the arbitrator or by the court.

The Ontario Task Force on Insurance endorsed arbitration along the lines set out in sections 125 and 207(8) of the Insurance Act. The Task Force saw no need for a publicly funded administrative tribunal to deal with first party automobile insurance policy disputes. I agree with that assessment. It seems to me that the Bar and the insurance industry, after joint consultation, should establish a regionalized roster of acceptable arbitrators. Half would come from the Bar and half from the insurance industry, including independent adjusters. The set-up should be regionalized. If acceptable to the insured and the insurer, one arbitrator could be used. Otherwise, each party could select an arbitrator from the established roster and the two selected could select the third. Decisions of the board of arbitration would be binding.

Alternative access to arbitration could be provided within the court structure. Serious consideration ought to be given to establishing an arbitration division within the court system. Judges involved should have some specific interest and expertise. This would permit binding, fast track consensual arbitration for disputes where the parties seek this relatively inexpensive resolution. This might be particularly useful in resolving first party automobile insurance disputes; however, I can see no reason to restrict this concept to automobile insurance-related problems.

Disputes as to available no fault benefits should not delay third party tort system litigation. The third party insurer should be entitled to take appropriate action to force the third party insurer to pay no fault benefits in appropriate cases. Where possible, the third party action should proceed without being delayed by the difference of opinion between the first party and third party insurers. In cases involving no fault benefits to be paid after trial or settlement, no fault benefits received by the claimants should be held in trust for the third party insurer as set out in Cox v. Carter[4] or the claimant could be required to assign no fault benefit rights to the third party insurer.

E. UNINSURED DRIVERS

There is no evidence to suggest that there has been any substantial increase in the number of uninsured drivers. That, however, does not mean there is no

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[4] (1976) 13 O.R. (2d) 717 (Ont. H.C.).

problem. Those who choose to drive without insurance force other motorists, who have secured insurance required by law, to pay additional premiums. The fine for driving without insurance coverage should be increased. Anyone convicted of driving without insurance should be exposed to an automatic licence suspension in addition to a fine. Driving privileges should not be restored until the offender has filed proof of financial responsibility. In practical terms that will simply require the offender to obtain insurance. Affordability is not a realistic mitigating factor. If a person's driving record is so bad as to make insurance unduly expensive, that person should not drive.

F. INFORMATION SYSTEMS

Many of the problems in the marketing of automobile insurance are a direct result of a somewhat primitive information system. The inability of brokers to verify information quickly and efficiently leads to increased policy costs and, in turn, to higher premiums. It is known within the insurance industry that new business loss ratios are higher than loss ratios for existing business. One of the reasons for this is the insurer's inability to quickly and accurately obtain and verify information about an applicant for insurance which would be of significance for premium rating purposes. Sometimes this information is never disclosed. On other occasions, the insurer will be made aware of relevant information when it is too late, that is, after an at-fault accident has occurred. On still other occasions, an applicant for insurance will, for example, assert a five-year claims-free driving record and be quoted the appropriate premium. The insurer may then determine that the insured has had two motor vehicle

accidents in the last five years. This will result in the policy being terminated or the insurer submitting an amended premium notice. The insured may or may not respond by paying the additional premium. In any event, the transaction costs directly related to issuing this policy will be substantially increased.

What is required is a standardized data base which provides insurers with an applicant's name, address, claims history, etc. This sounds relatively simple, but it is something the insurance industry in Ontario does not have now. Any workable data base will require 100% cooperation in the sense of a complete exchange of information by the insurance industry. That cooperation does not now exist. Because complete cooperation within the insurance industry cannot be guaranteed, it seems to me that legislation will be required.

Furthermore, insurers must have quick, efficient access to an applicant's driving record. This will allow convictions to be used as a rating factor. This is both ethically and actuarially sound. Conviction data are available now; there are, however, two problems. Search costs are too high at $5.00 a search and the information is not available quickly as the search now must be done manually. Driver record information including conviction records should be on-line and available to all insurers. In Alberta, brokers have government computer terminals which provide Alberta insurers with immediate access to driving records. It seems to me all licensed insurers should pay a yearly fee, based on market share, to obtain this on-line computer linkup. This would permit the provincial government to provide driver records to insurers on a break-even basis. It should be noted it is

consumers who tend to be the losers because of the absence of a workable industry data base.

Confidentiality of data relating to driver records has been raised as an issue by some in two respects. First, it is suggested the person's driving record is a private matter and hence not something to be subject to the insurance industry's scrutiny. Second, in Ontario, there seems to be a confidentiality concern about young offender conviction records. This latter concern is relevant to 16 and 17-year-old principal or occasional drivers. I reject both concerns. Insurers should be entitled to verify an applicant's claims and driving record. In particular, there is nothing confidential about a Highway Traffic Act or Criminal Code conviction. They are public matters. The young offender's driving record should not be confidential, as long as 16 and 17-year-olds are entitled to drive. Only Ontario has expressed a concern in this regard.

There is a further benefit to the full disclosure of driver records and claims information. If Ontario drivers knew their driving and claims records would be consistently available to all Ontario insurers and that convictions and at-fault accidents would affect premiums, there would be a positive effect on driving behaviour. If deterrence benefits are to be achieved through the potential of insurance premium increases, driver records must be available to all insurers and the public must be made aware that driving-related convictions will lead to increased premiums.

The remaining problem concerns uninsured drivers. Currently, when the vehicle owner wishes to register a

vehicle with the province, the owner must supply evidence that the provisions of the Compulsory Automobile Insurance Act have been complied with. The Ministry of Transportation and Communications, (the Ministry responsible for vehicle registration) does not consider it to be its responsibility to verify the existence of insurance coverage. I have been told by those involved with licensing vehicles that as long as the vehicle owner indicates the name of an insurer, however fictitious it may be, vehicle registration is completed. When the Ministry attempts to check whether an automobile insurance policy is in force, the process takes approximately three weeks. This system, or lack of it, substantially reduces the prospect of any real enforcement of compulsory insurance laws in Ontario. The solution lies in a better information system. This can be achieved by more efficient access to existing information. It is to be emphasized that the issue is access to existing information, not the development of new information. Cooperation is essential to the exercise. The cost involved should not be significant.

In the circumstances, I have these recommendations:

(1) that the Ministry of Transportation and Communications act immediately to transfer driver records to computer and that the information be available on-line to all licensed Ontario automobile insurers for a yearly fee based on market share;

(2) that a cooperative information network be established between the Registrar of Motor Vehicles and licensed Ontario automobile insurers to permit the immediate verification of

automobile insurance coverage. Further, it should be a Ministry responsibility to ensure that any person registering a motor vehicle has the required insurance coverage;

(3) that all licensed Ontario automobile insurers be required to be part of an information system. Thus, all insurers should be required to submit claims histories of their insureds to the data base; all insurers would have access to that information.

CHAPTER 14

CONSTITUTIONAL CONSIDERATIONS

Some of the issues I have been asked to consider raise questions as to their constitutionality and, in particular, as to the likelihood of any infringement of the Canadian Charter of Rights and Freedoms (the Charter). Since one criterion of any recommended system is that it be lawful, I felt it important to address these constitutional issues. In doing so, I have had the benefit of the opinion of Peter Hogg, Professor of Law at Osgoode Hall Law School.[1] In what follows, I make extensive reference to Professor Hogg's views with which I am in general agreement.

In my opinion, three subjects warrant constitutional consideration. They are:

(1) the constitutional authority of a provincial legislature to enact a no fault or threshold system of compensation for injuries arising out of motor vehicle accidents;

(2) the constitutionality of age-based entitlement to no fault benefits and the benefits for non-income earners under the standard automobile insurance policy; and

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[1] Professor Hogg's opinion for the Inquiry is found at Inquiry Research Study III. His opinion for the I.B.C. on "Age, sex and marital status" rating classifications is found at Appendix XII.

(3) the constitutionality of using "age, sex and marital status" as premium rating factors.

A. THE CONSTITUTIONALITY OF NO FAULT AND THRESHOLD SCHEMES

For the purpose of considering the constitutionality of no fault and threshold plans, I am prepared to assume that:

(i) a no fault regime provides less benefits than common law damages; and

(ii) no fault will deprive some or all victims of a tort action in the courts.

The constitutional attack made on compensation schemes which limit or take away the right to sue is that they violate sections 7 and 15 of the Charter. Both Professor Hogg and Neil Finkelstein who delivered an opinion on behalf of the I.B.C.,[2] concluded that a no fault or threshold no fault plan would not infringe either section 7 or section 15, but even if it did, such a plan would be justified under section 1 of the Charter. An opinion submitted on behalf of the C.B.A.O.[3] concluded the opposite--that denying or restricting access to the courts infringed both sections 7 and 15 of the Charter and could not be justified under section 1. I am generally in agreement with the conclusions and analysis of Professor Hogg and Mr. Finkelstein. It follows that I do not agree with the C.B.A.O. opinion.

Before addressing the Charter issues, I deal briefly with two other constitutional issues.

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[2] See I.B.C. submission, Appendix 4.

[3] The C.B.A.O. opinion is not attributed to any author.

(a) The Distribution of Powers Issue

Under the distribution of legislative power in sections 91 and 92 of the Constitution Act, 1867, it is clear that the province, by virtue of section 92(13), has legislative authority to create, modify or abrogate causes of action in tort.[4] Equally, a province has legislative authority in relation to automobile insurance and the authority to enact a no fault regime.[5]

(b) The Section 96 Issue

The administration of a no fault motor vehicle accident plan by an administrative agency rather than the courts does not offend section 96 of the Constitution Act. Workers' compensation boards have survived section 96 challenges[6] as has the Quebec Régie.[7]

(c) Section 7 of the Charter

Section 7 provides as follows:

> 7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

There is some dispute as to whether section 7 contains a separate right to "life, liberty and security of the person" or whether this right may be diminished in

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[4] MacDonald v. Vapour Canada, [1977] 2 S.C.R. 174.

[5] Canadian Indemnity Co. v. A.G. B.C., [1977] 2 S.C.R. 504.

[6] See, for example, Farrell v. Workmens' Compensation Board, [1961] 2 S.C.R. 48.

[7] Tardif v. Berube (1986), 34 D.L.R (4th) 24.

accordance with the principles of fundamental justice. Most of the case law supports the latter view, so that there is no infringement of section 7, absent a deprivation of fundamental justice.[8] Accordingly, the first question to be considered under section 7 is whether the right to "liberty" or "security of the person" includes a right to sue in tort. If it does, then the second question is whether the right to sue has been taken away in violation of the principles of fundamental justice. Only if both questions are answered in the affirmative is there a breach of section 7.

As both Professor Hogg and Mr. Finkelstein observe, there is not as yet a settled definition as to the content of the opening words of section 7.[9] The Ontario Court of Appeal in R. v. Morgentaler, Smoling and Scott[10] said as follows:

> Some rights have their basis in common law or statute law. Some are so deeply rooted in our traditions and way of life as to be fundamental and could be classified as part of life, liberty and security of the person. The right to choose one's partner in marriage, and the decision whether or not to have children, would fall in this category, as would the right to physical

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[8] See, for example, Singh v. Minister of Employment and Immigration, [1985] 1 S.C.R. 177 at 212 (Wilson, J. for three of six judges). R. v. Morgentaler, Smoling and Scott (1985), 52 O.R. (2d) 353.

[9] At the broad end of the spectrum, Madam Justice Wilson in Operation Dismantle v. The Queen, [1985] 1 S.C.R. 441, spoke of freedom from governmental constraint. At the other end of the spectrum, the Ontario Court of Appeal in R. v. Videoflicks Ltd. (1984), 48 O.R. (2d) 395, took the view that section 7 applies only in respect of a person's physical or mental well-being.

[10] (1985), 52 O.R. (2d) 353.

> control of one's person, such as the right to clothe oneself, take medical advice and decide whether or not to act on this advice.[11]

I agree with Professor Hogg when he says:

> It seems to me to be unlikely that the Supreme Court of Canada would decide that a cause of action in tort which has not yet accrued is within the words liberty or security of the person. That amounts to saying that everyone has a legitimate and constitutionally protected expectation that the common law will not be changed to his or her detriment in the future.

Even if liberty or security of the person in section 7 does include the right to sue in tort, a breach of section 7 will only occur if the right has been taken away in violation of the principles of fundamental justice. The principal case on the meaning of "fundamental justice" is the Supreme Court of Canada's decision in Reference re Section 94(2) of the Motor Vehicle Act (British Columbia).[12] Mr. Justice Lamer for the majority stated:

> Thus, ss. 8 to 14 provide an invaluable key to the meaning of 'principles of fundamental justice'. Many have been developed over time as presumptions of the common law, others have found expression in the international conventions on human rights. All have been recognized as essential elements of a system for the administration of justice which is founded upon a belief in 'the dignity and worth of the human person' (preamble to the Canadian Bill of Rights, R.S.C. 1970, App. II) and on 'the rule of law' (preamble to the Canadian Charter of Rights and Freedoms).

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[11] R v. Morgentaler, (1985), 52 O.R. (2d) 377.

[12] [1985] 2 S.C.R. 486.

> It is this common thread which, in my view, must guide us in determining the scope and content of 'principles of fundamental justice'. In other words, the principles of fundamental justice are to be found in the basic tenets of our legal system. They do not lie in the realm of general public policy but in the inherent domain of the judiciary as guardian of the justice system. Such an approach to the interpretation of 'principles of fundamental justice' is consistent with the wording structure of s. 7, the context of the section, i.e., ss. 8 to 14, and the character and larger objects of the Charter itself. It provides meaningful content for the s. 7 guarantee all the while avoiding adjudication of policy matters.[13]

None of the guarantees in sections 8 to 14 of the Charter which are said to be an "invaluable key" to the interpretation of section 7 suggest that access to the court for a civil wrong is a basic tenet of our legal system. Workers' compensation schemes have existed in Ontario and elsewhere for well over half a century. Furthermore, sections 8 to 14 of the Charter do not suggest that civil liability must always be premised on fault. As Hogg points out, the common law imposes liability on a basis other than fault in a number of situations (vicarious liability of the master for the torts of his servant, the doctrine in Rylands v. Fletcher, etc.). More generally, to paraphrase the language of Mr. Justice Lamer, whether compensation for motor vehicle accident victims should be through the civil courts on a fault basis or through an administrative agency on a no fault basis is "in the realm of general public policy", not in the "inherent domain of the judiciary as guardian of the justice system".

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[13] R v. Morgentaler (1985), 52 O.R. (2d) 503.

In R. v. Morgentaler, et al., the Ontario Court of Appeal also said:

> After considering the above decisions we have concluded that in applying the principles of fundamental justice the Court is not limited to procedural review but may also review the substance of legislation. While the limits of such review will evolve as the interpretation of the Charter unfolds, it is sufficient to say at this juncture that such substantive review should take only in exceptional cases where there has been a marked departure from the norm of civil or criminal liability resulting in the infringement of liberty or in some other injustice. We reiterate that the policy and wisdom of legislation should remain first and foremost a matter for Parliament and the Legislatures.[14]

As Finkelstein notes, it has long been a principle of Anglo-Canadian law that the provincial legislatures may create or abolish causes of action in the public interest. There is nothing to suggest that taking away the right to sue for damages arising from motor vehicle accidents and replacing it with a no fault compensation scheme is an exceptional case or a "marked departure from the norm". In my opinion, replacing a tort action with a no fault plan does not violate any principles of fundamental justice.

In Public Trustee (Alberta) v. Workers' Compensation Board,[15] Mr. Justice Bracco of the Alberta Court of Queen's Bench held that the provision of the Alberta Workers' Compensation Act that prevents an injured worker

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[14] (1985), 52 O.R. (2d) 385.

[15] Released August 13, 1987, as yet unreported.

from suing a third party employer is contrary to sections 7 and 15 of the Charter. This case was decided after I received Professor Hogg's opinion. Professor Hogg, however, was good enough to address the case in a short addendum with which I agree entirely. Mr. Justice Bracco seems to find in the principles of fundamental justice a principle of "fair exchange". He suggests that a worker gets nothing in return for the denial of a tort action against the third party employer. I concur with Professor Hogg[16] who concluded that since the denial of a right to sue in tort is not a breach of section 7 , the question whether a victim gets anything in return is irrelevant. In my opinion, there is no fair exchange principle within section 7. But even if there were, it cannot be argued that in the workers' compensation context employees get nothing in return for giving up the right to sue; so too in the motor vehicle context. Some victims who would get nothing in the tort system would be compensated under no fault. Others who would be compensated in tort may prefer the advantages of no fault. Ultimately, it is a question of values and policy as to which system is preferable. This is preeminently a matter for the Legislature and not for the courts.

As both Professor Hogg and Finkelstein correctly point out, their conclusions are strongly supported by American case law.[17] The due process clause in the 14th

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[16]This decision was released after Professor Hogg delivered his opinion to the Inquiry. He wrote a short addendum to his opinion dealing specifically with Mr. Justice Bracco's reasons. See Inquiry Research Study III.

[17]The C.B.A.O. opinion makes no reference to United States case law.

Amendment to the United States Constitution is the functional equivalent of section 7 of the Charter. The United States Supreme Court has consistently held that it is not a denial of due process to replace a tort action with a no fault regime. In New York Central Railroad Co. v. White,[18] the Court upheld a New York workers' compensation law stating in part, "No person has a vested interest in any rule of law entitling him to insist that it shall remain unchanged for his benefit". In the more recent case of Duke Power Co. v. Carolina Environmental Study Group,[19] the Court dealt with a Congressional statute which abolished tort actions in the event of a nuclear disaster and substituted limited no fault benefits. Chief Justice Burger for the Court held this did not breach the Constitution. In his reasons he said the following:

> Initially, it is not clear at all that the Due Process Clause in fact requires that a legislatively enacted compensation scheme either duplicate the recovery at common law or provide a reasonable substitute remedy. However, we need not resolve this question here since the Price-Anderson Act does, in our view, provide a reasonably just substitute for the common law or state tort law remedies it replaces...
>
> The legislative history of the liability-limitation provisions and the accompanying compensation mechanism reflects Congress' determination that reliance on state tort law remedies and state-court procedures was an unsatisfactory approach to assuring public compensation for nuclear accidents, while at the same time providing the necessary incentives for

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[18] (1917), 243 U.S. 188.

[19] (1978), 438 U.S. 59.

private development of nuclear-produced energy.[20]

Of course, many American states have enacted threshold or no fault schemes for motor vehicle accidents. None as yet have been considered by the United States Supreme Court, but as Professor Hogg observes, there has been extensive litigation in state courts, and constitutional challenges have generally been unsuccessful. I consider these cases in the discussion of section 15 of the Charter.

(d) Section 15 of the Charter

Section 15(1) provides as follows:

> 15.(1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

The argument that section 15 is infringed by a no fault scheme is that the victims of motor vehicle accidents are treated differently from the victims of other kinds of accidents. A further argument made with respect to threshold schemes is that there is inequality between motor vehicle accident victims themselves in that some maintain the right to sue while others do not.

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[20] Duke Power Co. v. Carolina Environmental (1978), 438 U.S. 59.

It is clear from the language of section 15 that the enumerated grounds of discrimination are not exhaustive and that other non-enumerated grounds can violate section 15. It also seems clear that not every legislative distinction contravenes section 15 because if that were the case virtually every statute would fall on that basis. What is not yet clear is what non-enumerated grounds are forbidden by section 15. A number of provincial appellate courts have considered this issue.

In Re Andrews and The Law Society of British Columbia,[21] Madam Justice McLaughlin of the British Columbia Court of Appeal set out the general proposition that:

> The essential meaning of the constitutional requirement of equal protection and equal benefit is that persons who are similarly situated be similarly treated and conversely that persons who are differently situated be differently treated.

In our own Court of Appeal, Mr. Justice Morden in R. v. R.L.[22] stated:

> ... The essentially relational nature of equality has been described as follows: 'The concept of equality is, by definition, relational or comparative. A person can only be found to be equal in relation to or in comparison with some other person who serves as a standard or criterion.' Monroe H. Freedman, 'Equality in the Administration of Criminal Justice', Nomos IX (1967) 250 at pp. 253-4. The concern for equality is that those who are similarly situated with respect to the purpose of the law be treated similarly: see Tussman

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[21] (1986), 27 D.L.R. (4th) 600. The case has been argued in the Supreme Court of Canada and judgment is under reserve.

[22] (1986), 26 C.C.C. (3d) 417.

> and tenBroek...and Re McDonald and the Queen...referring to the Tussman and tenBroek article.

In my opinion, it can be fairly argued that motor vehicle accident victims and other accident victims are not similarly situated. Automobile insurance, both for third party and limited first party coverage, is compulsory; automobile accident victims have some, albeit limited, no fault benefits; driving is a pervasive and dangerous activity; other accident victims (for example, workers) have been denied the right to sue. If motor vehicle accident victims are not similarly situated, there has been no denial of equality.

If they are similarly situated, then the crucial question is whether the difference in their treatment constitutes discrimination within section 15. Provincial appellate courts and the Federal Court of Appeal have disagreed on the proper interpretation of the words "without discrimination" in section 15(1). One view is that the words should be read in a neutral sense with the result that any legislature distinction would violate section 15(1) and would have to be justified under section 1.[23] At the other end of the spectrum is the view that "discrimination" in section 15(1) is not neutral but connotes treatment which is both pejorative and unreasonable. The notion that there is some standard of "reasonableness" within section 15(1) is reflected in the

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[23] Professor Hogg took this view in his text. He now concedes it is a minority view. I consider the section 1 issue separately.

judgment of Madam Justice McLaughlin in Andrews.[24] On this view, there is little room left for the operation of section 1.

In its judgment in the university mandatory retirement cases, McKinney v. University of Guelph et al.,[25] released December 10, 1987, the Ontario Court of

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[24] In Andrews, Madam Justice McLaughlin held:

> My response to the first question [about the nature of the analysis under s. 15] is that the question to be answered under s. 15 should be whether the impugned distinction is reasonable or fair, having regard to the purposes and aims and its effect on persons adversely affected. I use the word 'fair' as well as 'reasonable' to emphasize that the test is not one of pure rationality but one connoting the treatment of persons in ways which are not unduly prejudicial to them. The test must be objective, and the discrimination must be proved on a balance of probabilities: R. v. Oakes, supra (applying this test to s. 1). The ultimate question is whether a fair minded person, weighing the purposes of legislation against its effects on the individuals affected, and giving due weight to the right of the Legislature to pass laws for the good of all, would conclude that the legislative means adopted are unreasonable or unfair.

Andrews was referred to with approval by the Ontario Court of Appeal in R. v. Century 21 Ramos Realty (1987), 58 O.R. (2d) 737 and in British Columbia in Re Cramer and B.C. Teachers Federation (1986), 29 D.L.R. (4th) 681; however, the Andrews approach was rejected by the Nova Scotia Court of Appeal in Reference Re Family Benefits Act (1986), 75 N.S.R (2d) 338 and by the Federal Court of Appeal in Smith, Kline & French et al. v. Attorney General of Canada (1986), 12 C.P.R. (3d) 385. The Supreme Court of Canada has yet to address this issue.

[25] Unreported. The judgment of Mr. Justice Gray at trial is reported at (1986), 57 O.R. (2d) 1. The Court of Appeal sat as a five-man court. Mr. Justice Blair dissented on

Appeal rejected both the neutral and the Andrews interpretations of "discrimination". Instead, it adopted an interpretation which lay between these two positions. In the opinion of the Ontario Court of Appeal "discrimination" within section 15(1) comprises "treatment which, viewed objectively, is tangibly adverse, unfavourable or prejudicial".[26] The Court rejected the view that an applicant must demonstrate that the impugned legislation is also unreasonable or unfair to make out a prima facie breach of section 15(1). The Ontario Court of Appeal concluded that reasonableness is an issue which must be determined within the context of section 1.[27]

In my opinion, while one can agree or disagree with the policy behind a no fault scheme, it would meet the test set out by the Ontario Court of Appeal in McKinney. Legislation providing an adequate level of benefits delivered in a timely fashion without regard to fault, and emphasizing rehabilitation, should not be considered adverse, unfavourable or prejudicial having regard to the purposes of such legislation.[28]

I agree with Professor Hogg's observation that while a universal system of no fault compensation would satisfy

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the application of s. 1 of the Charter.

[26] Unreported Reasons, p. 55.

[27] This very much affects the onus. A party challenging legislation obviously has a lesser burden if he or she does not have to demonstrate "unreasonableness" as Andrews seems to require.

[28] A fortiori an automobile no fault scheme would not infringe subsection 15(1) on the Andrews test.

section 15, it is also constitutional for reform to proceed in stages. The judgment of the Supreme Court of Canada in Edwards Books and Art Limited v. The Queen[29] indicates that the Legislature is entitled to be selective in its decisions about how far to go in addressing social problems. Just as in the Edwards Books case, the Legislature did not have to provide a "pause day" for all workers in order for the legislation protecting some workers[30] to be valid, so too legislation does not have to provide no fault coverage for all accident victims before a scheme for motor vehicle accident victims will be upheld.

The C.B.A.O. constitutional opinion relies heavily on three trial judgments--Piercey Estates v. General Bakeries Ltd.,[31] Streng v. Township of Winchester[32] and Kask v. Shimizu[33]--to support its submission that a no fault or threshold scheme would violate section 15 of the Charter.

Only Piercey raises a similar issue. In that case, Chief Justice Hickman, at trial, concluded that the denial of the right to sue in tort, found in section 32 of the Newfoundland Workers' Compensation Act, contravenes

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[29] [1986] 2 S.C.R. 713.

[30] Workers in retail stores only.

[31] (1986), 31 D.L.R. (4th) 373.

[32] (1986), 56 O.R. (2d) 649.

[33] (1986), 28 D.L.R (4th) 64.

section 15 of the Charter.[34] Both Professor Hogg and Finkelstein are of the opinion that the Piercey case was wrongly decided at trial. Their opinions have been reinforced by the Newfoundland Court of Appeal in a decision rendered October 23, 1987. The five-member court, on a Reference which had its roots in the Piercey case, unanimously decided that section 32 of the Newfoundland statute is constitutional. Chief Justice Goodridge for himself and three others stated:

> The workers and their dependants to whom the Act applies are deprived of the benefits which might otherwise be available to them but have all the benefits available to them under the Act. The Legislature has ordained that some

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[34] The ruling on section 15 was not strictly necessary for the decision because the facts of the case arose in 1984, before section 15 came into force. The decision was contrary to Re Terzian and W.C.B. (1983), 42 O.R. (2d) 144, where Mr. Justice Krever for the Ontario Divisional Court said:

> We are all of the view that the right to bring action for damages in the circumstances of this case is not a matter that falls within the meaning of 'security of the person' as those words are found in s. 7 of the Canadian Charter of Rights and Freedoms.
>
> Nor do we think that it can be said that the plaintiffs are denied any Charter-protected rights otherwise than in accordance with the principles of fundamental justice.
>
> Finally, and in any event, if it were necessary so to decide, we add that we are not persuaded that s. 15 of the Workmens' Compensation Act cannot be demonstrably justified in a free and democratic society. Moreover, s. 26 of the Charter does not assist the applicants.

To the same effect see Re Ryan (1984), 28 A.C.W.S. (2d) 203 (Div. Ct.) and Budge v. Workers' Compensation Board (1985), 1 W.W.R. 437 (Alta. Q.B.).

will receive more, some will receive less, than they otherwise might. This is the manner that has been chosen to structure the social regime of Workers' Compensation.

It is not required that the Legislature choose the best method. The Charter does not, and the Court cannot, require that legislative policy be perfect. If the scheme is reasonable and fair when viewed globally, it will not be condemned, notwithstanding that it may have imperfections...

The Charter was not designed to interfere with beneficial social programs of the Legislature. It was not designed to regulate or patrol these programs. Only where there is contained in the program something that is unfair or unreasonable will courts interfere.

The workers' compensation scheme provides a stable system of compensation free of the uncertainties that would otherwise prevail. While there may be those who would receive less under the Act than otherwise, when the structure is viewed in total, this is but a negative feature of an otherwise positive plan and does not warrant the condemnation of the legislation that makes it possible. Judicial deference to the legislative will is required here.

Upon an overview, the scheme of compensation under the Act cannot be said to be either unfair or unreasonable. While there may be inequalities, there is no discrimination and the legislation cannot be condemned as being inconsistent with s. 15(1) of the Charter.

Mr. Justice Morgan delivered a separate concurring opinion in which he stated:

Accepting that the classification of industrial workers into a separate category for the purposes of the Act is valid, the question for determination is whether section 32 creates an inequality by depriving workers and their dependants of a 'right of action' against an employer for work-related injuries or death. In my respectful opinion it does not. All workers are entitled to the benefit provided by the

> Act and regulations. In return for those statutory benefits, the 'right of action' to assert a claim for compensation in tort is taken away from all. To find an inequality by comparing those covered by the Act with those not so covered and therefore free to take an action in tort one must ignore the underlying purpose of the Act and the myriad of benefits enjoyed by those covered by the Act and not available to those others. In my view any economic loss that may be sustained by the taking away of the 'right of action' for work-related injuries is more than off-set by the overall benefit of the Act and is a necessary incident to the implementation of a valid legislative scheme.

The decision is consistent with other provincial case law holding that workers' compensation legislation does not violate the Charter. In my view, similar reasoning may be applied to automobile no fault plans.

In Streng, Mr. Justice Smith struck down the three-month limitation period applicable to actions against municipalities as being contrary to section 15 of the Charter. Mr. Justice Smith in his judgment, accepted that motor vehicle accident victims could be treated as a distinct class without violating section 15 of the Charter. In his reasons, he stated:

> ...s. 15 should be so interpreted as to allow the courts to strike down all irrelevant or unreasonable classifications that result in certain individuals having the benefit of a law or the protection of a right, in this instance the right to claim damages, and yet in the case of other individuals similarly situated having the same right taken away. The class created here is that of persons suffering personal injuries as a result of the negligence of others. The class may be further narrowed by including only those suffering injuries in car accidents. All members of such a class are

> entitled to expect in the normal course, to be treated alike.[35] [emphasis added]

Thus, Streng provides no support for a constitutional attack on an automobile no fault plan. Moreover, Streng was not followed in the later Ontario case of Mirhadizadeh v. The Queen.[36]

The last case is Kask in which Mr. Justice MacDonald of the Alberta Queen's Bench struck down a rule of practice requiring non-resident plaintiffs to post security for costs. Again, other courts faced with the same issue have taken a different view.[37] Differentiation based on poverty or place of residence is much harder to justify than the differentiation being dealt with here.

In summary, of the main cases relied upon by the C.B.A.O. opinion, the most important one has been overturned and the other two are in my view of no assistance to its position.

(e) Threshold Schemes

Having concluded that a no fault scheme does not infringe section 15 of the Charter, the remaining issue is whether section 15 is infringed by a threshold plan in which the right to sue in tort is preserved for some but not all motor vehicle accident victims.

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[35] See footnote 27 at p. 657.

[36] (1986), 57 O.R. (2d) 441.

[37] Singh v. Dura, [1987] 4 W.W.R. 549 (Alta. Q.B.); Nissho Corp v. Bank of British Columbia et al. (1987), 39 D.L.R. (4th) 453 (Alta. Q.B.).

In the United States, the 14th Amendment guarantees "The equal protection of the laws". Equal protection has been interpreted in American courts as requiring a rational basis for legislative differentiation. The rational basis test requires that the impugned legislation must be a reasonable means to achieve a legitimate public purpose.[38] It is a test which is similar to that propounded in Andrews.

Many of the American threshold plans have been attacked on equal protection grounds. As Professor Hogg observes, only in rare instances have U.S. courts struck down these plans.[39] In an Opinion of the Justices,[40] a majority of the Supreme Court of New Hampshire held that elimination of the right to recover damages for pain and suffering below a prescribed threshold did not violate either state or federal constitutional provisions. The Court held in part:

> Those injured persons who do not meet the threshold are not left without remedy. A new system of recovery is substituted for the existing remedy. It is similar in many respects to our Workmen's Compensation Act...The constitutionality of such statutes, which have been considered as reforms of the common law of torts, is not 'firmly established'... We are of the opinion that this similar reform in the law relating to automobile injuries also meets due process requirements. The threshold used as a criterium to delineate when damages for pain and

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[38] United States courts apply a stricter test to "suspect" categories, for example, race.

[39] Josephine King, "Constitutionality of No-Fault Jurisprudence," Utah L. Rev. 4 (1982):797.

[40] (1973), 304 A (2d) 881.

> suffering are recoverable and when they are not cannot be said to be arbitrary or unreasonable... We are of the opinion that House bill 79 bears a rational relation to a legitimate legislative objective and provides a reasonable substitute for existing rights. Pinnick v. Cleary...

With respect to determining the threshold, the Court said that the appropriate test is whether the threshold

> ...would have a fair and substantial relation to the object of the legislation. There is no mathematical or logical way of fixing this point with precision. The judgment of the legislature must be accepted unless it is very wide of any reasonable line of demarcation.[41]

In Pinnick v. Cleary,[42] the Supreme Judicial Court of Massachusetts upheld that state's threshold plan holding, in part, that a cause of action in tort for personal injury sustained in a motor vehicle accident is not a vested property right which could not be altered or abolished by a statute creating a no fault personal injury insurance system. The Court was of the view that no person has a vested interest in a rule of law so as to entitle him to insist that it shall remain unchanged for his benefit. Reardon, J. stated:

> We thus perceive no basis for treating a legislative alteration of the tort action for personal injuries differently from an alteration of any other preexisting role of the common law. Hence we may summarily dispose of several of the plaintiff's arguments which are founded on the contrary premise. There is no cause here for application of the 'compelling state interest' test, which is employed where a

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[41] Opinion of the Justices (1973), 304A (2d) 886.

[42] 271 N.E. (2d) 592.

> statute impairs fundamental rights protected by the Constitution.[43]

In Shavers v. Kelley,[44] the Supreme Court of Michigan approved the constitutional validity of Michigan's threshold no fault plan, although it found certain aspects of the legislation unconstitutional and gave the Legislature 18 months from the date of the opinion to remedy the defects. The Court was of the opinion that the Legislature need not provide an adequate substitute remedy before abolishing a common law cause of action at tort, as long as the legislation bears a reasonable relationship to a permissible legislative objective.

With respect to equal protection, the majority of the Court said:

> The treatment of motor vehicle tortfeasors differently from all other tortfeasors does not violate the traditional test for equal protection. Exhibits were introduced at trial to show that motor vehicle accidents have consistently and by a wide margin been the principal cause of accidental injury and death in Michigan... The legislative judgment ... is justified by the predictably frequent and serious injury to persons and property resulting from the use of motor vehicles.[45]

Finally, in Gentile v. Altermatt,[46] the Supreme

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[43] Pinnick v. Cleary, 271 N.E. (2d) 600-601.

[44] (1978), 267 N.W. (2d) 72, certiorari denied at 442 U.S. 934.

[45] Shavers v. Kelley (1978), 267 N.W. (2d) 99.

[46] (1976), 363 A (2d) 1; appeal dismissed for want of a substantial federal question at 423 U.S. 1041.

Court of Connecticut upheld that state's threshold legislation. The Court said:

> The concept of general damages has been lost sight of and, in its place, there has emerged a system of frequent overcompensation for victims with minor injuries which, in effect, represent the price paid by liability insurers to forego the long, extensive process of litigation. An unfortunate concomitant of this has been the under-compensation of cases of a truly serious nature. If anything, the Act tends to be an equalizer, providing the more seriously injured the opportunity to seek true redress. Certainly, those injured who hover on either side of the $400.00 threshold may suggest imperfections in this system, in that one who incurs $399.99 in allowable expense fails to satisfy that criterion for exemption, while another incurring $400.01 in expenses is exempted. Yet in every instance where a line must be drawn or a cutoff established, there are those who fall directly on either side. This is but one of the vagaries of life to which we accustom ourselves and which we accept in our daily affairs, but we cannot, for this reason, find the Act unreasonable in its purpose and overall effect. We rely, instead, on the thought that no matter to which side of the line a party is placed his remedies are sufficient and reasonable.[47]

Any threshold plan is to some extent arbitrary; but one which seeks to remove less serious injuries from the tort system in order to fund the plan is justified in constitutional terms.

Threshold schemes are more constitutionally vulnerable than pure no fault schemes, but I am satisfied that a reasonable threshold scheme would on balance survive constitutional challenge under the Charter.

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[47] Gentile v. Altermatt (1976), 363A (2d) 77.

(f) Section 1 of the Charter

Since in my opinion no fault and threshold schemes do not violate either section 7 or section 15 of the Charter, resort to section 1 is unnecessary. If, however, I am incorrect in that assessment, in my view, a no fault scheme would be justified under section 1.

Section 1 of the Charter provides:

> The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

In R. v. Oakes, the Supreme Court of Canada set out the test to be met to save legislation under section 1.[48] First, the objective of the law must be "of sufficient importance to warrant overriding a constitutionally protected right or freedom". Second, the means used to accomplish the objective must be reasonable and demonstrably justified. This requires a three-fold proportionality inquiry: (a) the law must "be carefully designed to achieve the objective"; (b) it must "impair as little as possible the right in question"; and (c) it must not be disproportionally severe in its impact on the person whose right is limited.

The provision of guaranteed, speedy and comprehensive coverage to motor vehicle accident victims is surely a sufficiently important objective to satisfy

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[48] [1986] 1 S.C.R. 103.

the first test. Again, Edwards Books[49] is clear that a court will defer to a reasonable legislative judgment as to how far to go in addressing a social concern. Nor is there any reason to think that a reasonable no fault plan would not meet the proportionality requirements set out in Oakes.

B. CONSTITUTIONALITY OF NO FAULT BENEFITS

I also asked Professor Hogg to consider two specific constitutional questions in relation to the delivery of no fault benefits. The first question is whether a loss of income indemnity that terminates at age 65 infringes section 15. The second question is whether there are any constitutional difficulties in compensating non-income earners (for example students and housekeepers) on a no fault basis.

(a) Age-Based Entitlement

For the purpose of entitlement to disability benefits under Section B of the current standard automobile policy, an age distinction is made between those persons actively employed at the date of the accident and those deemed to be employed by virtue of being employed for 6 months of the preceding 12 months. For those deemed to be employed, entitlement to disability benefits commences at age 18 and terminates at age 65. For those actively employed, disability benefits begin at age 16 and continue, without regard to age, so long as the person remains entitled. My recommendation would allow

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[49] See footnote 29.

those deemed to be employed to receive benefits commencing at age 16. The I.B.C. proposal recommends terminating entitlement to disability benefits for those actively employed as well as those deemed to be employed at age 65. My recommendation would terminate entitlement at age 65 only for those deemed to be employed.

A number of constitutional issues arise out of these proposals:

(i) In my view while the use of age 65 may well be vulnerable to a section 15 challenge, in the context of its use as a cutoff point for eligibility for no fault automobile disability benefits (for the employed and probably for the deemed to be employed), the use of age 65 would likely be justified under section 1 of the Charter. The rationale for an age 65 termination is that 65 is still the usual retirement date when earned income stops and government income support or tax assisted private income support begins. The university mandatory retirement cases[50] have used similar reasoning to uphold age 65 retirement rules.[51]

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[50] McKinney v. University of Guelph (1986), 57 O.R. (2d) 1; affirmed by the Ontario Court of Appeal December 1987. In McKinney, the issue was whether the definition of "age" in section 9(a) of the Ontario Human Rights Code (limited to ages 18 to 65) contravened the Charter. The majority of the Court of Appeal upheld the provision under section 1 of the Charter in its application to university mandatory retirement policies. The Court emphasized it was not deciding the issue of mandatory retirement at age 65 outside the university context.

[51] See also Harrison v. University of British Columbia (1986), 30 D.L.R. (4th) 206; (reversed on appeal; 1987 unreported).

This point is somewhat academic in light of my recommendation not to terminate disability benefits at age 65, except for the deemed to be employed.

(ii) It would not, in my view, offend section 15 of the Charter to distinguish between those actively employed and those deemed to be employed by providing an age 65 termination date for the latter.

(iii) One area of constitutional difficulty is the use of age 18 as a commencement date for entitlement to disability benefits for those deemed to be employed. Persons aged 16 and 17 are qualified to drive and to work. There is no issue of a usual retirement date. In my view a good case can be made for saying that the age 18 commencement date for those deemed to be employed infringes section 15 and cannot be justified under section 1 of the Charter.

(b) Allowance for Non-Income Earners

This does not appear to raise any constitutional problem. Students and homemakers have no actual income loss. Accordingly, they have to be compensated on a basis that is somewhat arbitrary. As Professor Hogg observes, any bona fide attempt to deal fairly with them will not violate section 15 of the Charter.

C. RATING ON THE BASIS OF AGE, SEX AND MARITAL STATUS

As I have discussed in Chapter 7, the classification system used by Ontario automobile insurers has for a number of years included age, sex and marital status as rating factors. The use of these criteria for rating purposes is restricted to those insureds under age 25.

Both accident data and the claims experience of the industry indicate that drivers under age 25 have, on average, more accidents than those over 25; that men under 25 have more accidents than women under 25; and that single males under 25 have more accidents than married males under 25.[52] Age, sex and, to a lesser extent, marital status appear to be important indicators of accident probability.

In the last decade, age, sex and marital status have come under attack as being socially, ethically and legally unacceptable particularly having regard to the provisions of provincial human rights legislation and now sections 15 and 28 of the Charter. In October 1985, a Board of Inquiry[53] found that an insurer using age, sex and marital status as rating factors was in breach of sections 1 and 3 of the Ontario Human Rights Code which provide as follows:

> 1. Every person has a right to equal treatment with respect to services, goods and facilities, without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed,

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[52] See the discussion in Chapter 7.

[53] Re Bates and Zurich Ins. Co., [1985] I.L.R. 1-1942.

sex, age, marital status, family status or handicap.

3. Every person having legal capacity has a right to contract on equal terms without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, age, marital status, family status or handicap.

The Board held that the insurer could not bring itself within the exception in section 21 which reads as follows:

21. The right under sections 1 and 3 to equal treatment with respect to services and to contract on equal terms, without discrimination because of age, sex, marital status, family status or handicap is not infringed where a contract of automobile, life, accident or sickness or disability insurance or a contract of group insurance between an insurer and an association or person other than an employer, or a life annuity, differentiates or makes a distinction, exclusion or preference on reasonable and bona fide grounds because of age, sex, marital status, family status or handicap.

The Board of Inquiry held that the insurer's rate classification system for automobile insurance, with its use of the group factors of age, sex and marital status, was not "reasonable and bona fide". This decision, however, was reversed by the Divisional Court on appeal.[54] The Court, in its reasons, said the following:

> In short, the current classification system, although subject to future revision and current doubts, does embody distinctions supported by reasonable, actuarially verified statistics.

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[54] Re Bates and Zurich Ins. Co., [1987] I.L.R. 1-2148.

The question I wish to address here is whether the use of either age or sex as rating criteria offends section 15 (and, in the case of sex, section 28) of the Charter. I am less concerned about "marital status" as it would appear that the insurance industry itself has no particular interest in preserving it as part of the classification system.

In considering the Charter question, I have reviewed Professor Hogg's thoughtful opinion to the I.B.C. in August 1983.[55] Although written well before section 15 was proclaimed in force and therefore before any jurisprudence on the equality provisions of the Charter, it nevertheless provides a useful analysis of the relevant issues.

A threshold issue is whether the Charter has application to the classification system now used by Ontario's automobile insurers. In the very recent case of Retail, Wholesale and Department Store Union, Local 580 v. Dolphin Delivery Ltd.,[56] the Supreme Court of Canada confirmed the prevailing view that, by reason of section 32(1), the Charter does not apply to private activity, but applies only to relations between the individual and government. Some degree of government intervention, whether it be executive, administrative or legislative, is required to make the Charter applicable.

Since government approval for Facility Association rates is required by statute, it is reasonable to

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[55] Appendix XII.

[56] (1986), 33 D.L.R. (4th) 174.

conclude that the industry's rating criteria in the residual market are subject to the Charter.[57] Whether the rating practices of the industry in the voluntary market are subject to the Charter is a more difficult question. While premium rates in the voluntary market are unregulated, there is still fairly extensive governmental intervention in the automobile insurance industry. Automobile insurance is compulsory; private insurers are required to be licensed; the Statutory Conditions of the automobile insurance policy as the name implies are prescribed by statute; the Superintendent of Insurance exercises supervisory power over the industry. While the question is not free from doubt, I agree with Professor Hogg that on balance the Charter does not apply to the classification system and rating practices of Ontario's insurers in the voluntary market.[58]

The situation will be entirely different if Ontario passes into law the Automobile Insurance Board Act[59]. The draft legislation contemplates that the classification system will be prescribed by Cabinet by regulation. In that event, the classification system and the rating factors that are prescribed will be subject to the Charter. I pause to observe that, insofar as age, sex and marital status are concerned, the question may be academic

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[57] Compulsory Automobile Insurance Act, R.S.O. 1980, c. 83, s. 10.

[58] Further support for this conclusion may be found in the reasons of the Ontario Court of Appeal in McKinney v. University of Guelph et al. (judgment released December 10, 1987).

[59] See the discussion in Chapter 16.

since the government has clearly indicated these factors are not to be used in the new classification system.

To the extent the Charter does apply to the industry's rating criteria and to the extent age and sex may still be considered as appropriate factors, I offer a few tentative observations as to whether their use might infringe sections 15 and 28.

I agree with Professor Hogg that the use of age as a rating criterion is more likely to survive a Charter challenge than the use of sex.[60] Age has been used as a regulatory criterion in a wide range of activities--there is a minimum drinking age, a minimum age for obtaining a driver's licence, a minimum age for voting and so forth. It can at least be said that "youth is a 'disability' that every member of the community suffers in the course of his or her lifetime".[61] Age is not merely a proxy for driving experience; it is a predictive factor in its own right. Further, age has been accepted by courts both in Canada and the United States as meeting constitutional requirements of equality so long as there is a reasonable or rational basis for the distinction.[62]

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[60] In McKinney v. University of Guelph, the Ontario Court of Appeal rejected the view that there are different standards of scrutiny to be applied to the different grounds of discrimination in subsection 15(1). The extent that different section 15 rights are to be ranked differently is to be addressed by the Standard of review called for by section 1 of the Charter.

[61] Rea and Trebilcock, Rate Determination.

[62] See footnotes 46-48.

On the other hand, as Professor Hogg's opinion demonstrates, sex-based classifications are becoming increasingly difficult to maintain in the face of constitutional challenge.[63] Unlike age, sex is no more than a proxy; it is not predictive of accident probability in its own right. One important American case on the subject is Craig v. Boren[64] in which a state law prohibiting the sale of beer to males under 21 and females under 18 was struck down by the United States Supreme Court as violating the constitutional right to equal protection. Even though the state produced statistical evidence showing that young men were arrested for alcohol-related offences more frequently than young women, that they were killed in traffic accidents more frequently and that drunkenness was a factor in many accidents, Mr. Justice Brennan for the majority held "the showing offered by the (government) does not satisfy us that sex represents a legitimate, accurate proxy for the regulation of drinking and driving."[65]

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[63] In addition to the American cases cited by Professor Hogg, see for example Re Blainey and Ontario Hockey Association (1986), 26 D.L.R. (4th) 728 (C.A.).

[64] (1976), 429 U.S. 190.

[65] See also Los Angeles Department of Water and Power v. Manhart (1978), 435 U.S. 702 and Arizona Governing Committee v. Norris (1983), 463 U.S. 1073. In these two cases, the Supreme Court of the United States prohibited gender-based distinctions in insurance as being contrary to Title VII of the Civil Rights Act of 1964. While neither decision dealt with the equal protection clause of the 14th Amendment, nonetheless the Court held that sex-based classifications in state pension plans were not lawful even though supported by actuarial evidence and life expectancy tables.

The difficulty of upholding sex-based distinctions in Canada is compounded by section 28 of the Charter. Given the absolute language of section 28 and the climate of public opinion in favour of sexual neutrality, it may well be the case as Professor Hogg concludes that the Supreme Court of Canada would be very reluctant to approve the use of sex as part of an insurer's classification system.

Before one comes to a final determination as to whether either classifying on the basis of age or sex infringes the Charter, it seems to me what is required is a more informed discussion of the alternatives. An assessment of the alternatives is important to determine whether age and sex are legitimate distinctions within section 15 or can be justified under section 1 of the Charter.[66] In practical terms, further consideration ought to be given to the extent to which neutral classification factors can be developed which are accurate substitutes for age or sex. These substitute factors will have to be measured against the generally accepted criteria for establishing cells within a classification system.[67] A further study of these issues is in my view critical before one too readily concludes that using age or even sex as rating factors infringes the Charter.[68] Constitutional issues aside, substitutes for age and sex as premium rating criteria should be exposed to ongoing assessment and evaluation.

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[66] I assume that sex discrimination may be justified under section 1 of the Charter notwithstanding the language of section 28.

[67] See for example Risk Classification -- A Statement of Principles by the Canadian Institute of Actuaries.

[68] See Rea and Trebilcock and see also Ryan, "The Elimination of Gender Discrimination in Insurance Pricing."

CHAPTER 15

PUBLIC OR PRIVATE AUTOMOBILE INSURANCE

A. INTRODUCTION

In four provinces in Canada (Saskatchewan, Manitoba, British Columbia and Quebec) automobile insurance is delivered by a government controlled monopoly. In Quebec, government delivery of automobile insurance is combined with a pure no fault system of compensation for motor vehicle accident victims. In the three western provinces which have public delivery systems, compensation for personal injuries is, as in Ontario, through the tort system with add on no fault accident benefits.

My terms of reference require me to consider whether Ontario should have public or private automobile insurance. This issue received scant consideration in the Report of the Ontario Task Force on Insurance. After recommending a no fault accident compensation system, the Report, without any elaboration, stated:

> The delivery of the no-tort accident compensation system should remain primarily in the hands of the private insurance industry -- at least so long as private insurance can demonstrate that it has the financial capacity to design and administer such a scheme at affordable premium levels.[1]

and,

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[1] Ontario Task Force on Insurance, A Pre-Publication of the Final Report (1986), Vol. I, p. 102.

> The basic scheme that is envisaged by the Task Force is a no-tort accident insurance policy designed and delivered by private industry...
>
> The Task Force believes that in Ontario the private insurance industry should have the opportunity to demonstrate whether and to what extent it can be counted on to deliver the insurance product.[2]

The Task Force's recommendation did not put the matter to rest. In the last year and a half the issue of public or private delivery of automobile insurance has received increasing attention in Ontario.

The New Democratic Party made a public automobile insurance system a basic policy position and an important part of its campaign platform in the most recent provincial election. Published comparisons of premiums for particular classes of drivers as between Ontario and the public systems has infused public awareness of the issue. The Ontario Government's announced freeze on premiums last April and its subsequent introduction of rate regulation legislation may be viewed at least in part as a response to the call for a public automobile insurance corporation.

Those who call for a public delivery system assume implicitly that there will be no private sector competition at least for the compulsory portion of the insurance product. In other words, it has been readily assumed that a publicly run automobile insurance corporation will be given a monopoly position in the sale

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[2] Ontario Task Force on Insurance, A Pre-Publication of the Final Report (1986), Vol. I, pp. 102-103.

of automobile insurance. This is indeed the situation that prevails in the four provinces that have public delivery systems. Competition is permitted only on optional coverage in British Columbia, Saskatchewan and Manitoba.[3] It is noteworthy that in Manitoba the Manitoba Public Insurance Company (M.P.I.C.) has both an automobile insurance division and a general insurance division. The former is given a monopoly position by statute; the latter, however, is required to compete with the private sector.

To the extent one seeks guidance from the experience of delivery systems in other jurisdictions with public delivery systems, I think it is a far more useful exercise to consider Saskatchewan, Manitoba and British Columbia (and especially the latter two provinces)[4] than Quebec. At least in the western provinces, the compensation system in place and the compulsory portion of the automobile insurance policy are similar to what exists in Ontario. By holding these elements constant, one can obtain a more meaningful comparison of the different delivery systems. In Quebec, the compensation and delivery systems are different from those in Ontario. With neither the delivery system nor the compensation system the same, a meaningful comparison of public or private delivery as

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[3] In the western provinces with public plans, private insurers cannot sell the compulsory portion of the product. They can compete on optional coverage. In practice, their market is very limited or non-existent. In Quebec private insurers sell collision coverage.

[4] The rating structure used in Manitoba and British Columbia permits a better comparison of the delivery systems. See the discussion later in this chapter.

between Ontario and Quebec would be extremely difficult, time consuming and costly.

As I will make frequent reference to the delivery of automobile insurance in Saskatchewan, Manitoba and British Columbia, a brief summary of the plans in place in those provinces is in order.

B. THE PUBLIC DELIVERY SYSTEMS IN WESTERN CANADA

Saskatchewan was the first province in Canada to engage in the insurance business. In 1944, the provincial government established a public corporation, the Saskatchewan General Insurance Office (S.G.I.O., now S.G.I.), to carry on the business of general insurance. In 1946, responding in part to the fact that only 12% of the province's motorists were insured, the Saskatchewan Legislature enacted the Automobile Accident Insurance Act. Pursuant to this statute, the S.G.I.O. was given exclusive rights to the compulsory portion of the automobile insurance market. The Saskatchewan plan is known as the Auto Fund. Effective January 1, 1984, the Auto Fund became a separate legal entity, although it continues to be administered by S.G.I.

In Manitoba, public automobile insurance emerged from the report of the Manitoba Automobile Insurance Committee which was established in 1969. The Committee recommended "A compulsory system of automobile insurance for all Manitoba residents to be administered by a crown corporation". The M.P.I.C. was established pursuant to the Manitoba Automobile Insurance Act 1970. The M.P.I.C. commenced operations November 1, 1971 to administer, as the exclusive supplier in the province, a comprehensive

automobile insurance plan known as Autopac. Statutory amendments in 1974 gave the M.P.I.C. legislative authority to operate in other fields of insurance. In July 1975, the M.P.I.C. commenced the operation of its general insurance division in competition with the private sector.

The Insurance Corporation of British Columbia (I.C.B.C.), a provincial Crown corporation, was created in 1973 with authority to engage in and carry on all classes of insurance. The I.C.B.C. opened its doors to the public March 1, 1974. Its General Insurance Services Division was sold to the private sector in February 1985. As a result, the I.C.B.C.'s sole responsibility is to administer Autoplan, the compulsory automobile insurance programme established under the British Columbia Automobile Insurance Act.

It is to be noted that the public automobile insurance plans in British Columbia, Saskatchewan and Manitoba operate as monopolies. Private sector insurers are foreclosed by statute from competing with the public plans.[5]

Coverage under the public plans in the western provinces is quite similar to coverage in Ontario. In all four provinces, third party liability, no fault accident benefits and uninsured/unidentified motorist coverage is compulsory. The mandatory third party liability limits are the same, $200,000. The right to sue in tort has not been removed or limited. Accident benefit payments are deducted from judgments obtained against third parties.

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[5] Competition is foreclosed on compulsory coverage.

There are also differences. In Manitoba and Saskatchewan, collision coverage is mandatory; in Ontario and British Columbia it is optional. The level of accident benefits varies in the different provinces. For example, the maximum weekly income indemnity in Ontario is $140/week compared to $300 in Manitoba. The maximum medical and rehabilitation expense payment is $25,000 in Ontario, compared to $10,000 in Saskatchewan, $20,000 in Manitoba and $100,000 in British Columbia. These differences have a minimal effect on premiums.

In addition to the compulsory automobile insurance package, excess coverage on an optional basis is available in all four jurisdictions. In each of the western provinces, the private sector is permitted to compete with the public plan for the optional business. In practice, however, because of the advantages of "one-stop shopping", all three Crown corporations account for a major share of the excess coverage market in their respective provinces.

C. LIMITATIONS OF COMPARATIVE ANALYSIS

I turn from this brief description of the public plans in operation in western Canada to a comparative analysis of the advantages and disadvantages of public and private automobile insurance systems. I do so in order to assess whether the establishment of a provincial Crown corporation for the delivery of automobile insurance in Ontario is in the public interest.

At the outset, I think it is important to recognize the limitations which circumscribe this comparative exercise. First and foremost is the lack of relevant

data. Published studies of the subject are scarce. When the Inquiry began there was in existence a report by the management consulting firm of Woods, Gordon & Co.--"Government Ownership of Automobile Insurance"--published in 1978 for the Ontario Select Committee on Company Law, but little else. This lack of material was compounded by the fact that empirical data from the I.C.B.C., the M.P.I.C. and the S.G.I. were also scarce. Neither the I.C.B.C., the M.P.I.C. nor S.G.I. are required to file information with the Federal Superintendent of Insurance, nor do they provide statistical experience data to the Insurance Bureau of Canada. Effectively, all that is available in published form are the rather sketchy data that are found in the annual reports of each Crown corporation.

Accordingly, I commissioned a research project which addressed both the state of competition in the Ontario automobile insurance industry and an efficiency comparison of the private sector delivery system in place in Ontario and the public sector delivery systems in place in British Columbia, Manitoba and Saskatchewan.[6] Counsel and I also travelled to western Canada where we held extensive discussions with those responsible for administering the public plans in each province as well as with other groups that came into contact with these plans. I am grateful for the time and cooperation given by those who spoke to us.

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[6] See Inquiry Research Study II. I also considered the Woods, Gordon Report referred to above. Because it is often referred to and because there is a scarcity of other data, I regard the Woods Gordon Report as important. I have dealt with it separately in a later section of this chapter.

A second limitation to a proper comparison is that public plans operate under a different set of constraints than do private automobile insurers. In fact, the public plans themselves are not identical with the I.C.B.C. at the one end operating more like a private insurer and the S.G.I./Auto Fund at the other, carrying on business in a manner incompatible with a private sector company. None of the public plans pay corporate income tax, and up until this year, one provincial Crown corporation, the I.C.B.C., did not pay any premium tax. It has been suggested that public plans do not pay market rates for services from the provincial civil service or may obtain the use of public buildings at less than competitive prices. In the minds of some, this suggestion, although not substantiated, has crystallized into a proven fact. I have not based my conclusions on the central issue of public automobile insurance on subsidization arguments of this nature.[7]

None of the matters referred to above make an evaluation of the overall performance of public and private delivery systems impossible, but they do make the exercise more difficult.

D. PREMIUM COMPARISONS

The case for publicly delivered automobile insurance is most frequently made by premium comparisons for different classes of drivers. The premium paid in Toronto by a 21-year-old single male who drives a 1984

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[7] Cross-subsidization within the plans is a different matter. See the discussion later in this chapter.

Honda Accord for pleasure, and work under 10 miles, and who has a five-year clear record is compared with the premium he would pay in Winnipeg, Regina or Vancouver. The premium paid in Ottawa by a 43-year-old married male with a 19-year-old son as an occasional driver is compared with the corresponding premium paid in Victoria.[8] The examples are endless. Selected comparisons can demonstrate significant disparities between the rates in Ontario cities and those in cities in the three western provinces with public plans. It is not surprising that such comparisons are made. When all is said and done, a chief concern of the Ontario driving public is to pay less for its automobile insurance premiums. If there are inherent advantages to a public delivery system that permit automobile insurance to be delivered at less cost than in the private sector, that would clearly be a very significant factor that would weigh in favour of a public system. However, the simplistic premium comparisons that have become popular are of no assistance whatsoever in assessing the comparative cost efficiency of public and private systems. Nor do they indicate what premiums Ontario drivers would pay if this province adopted public automobile insurance. In fact, these premium comparisons are misleading. The reasons are basically two-fold.

(a) Differences in Loss Costs (Pure Premiums)

To make any premium comparison meaningful all relevant characteristics must be held constant. These would certainly include the age and claims record of the

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[8] These are but two of the examples used by the NDP in its written submission to the Inquiry.

insured and the model, age and use of the insured vehicle. But even if these characteristics were held constant and even if the classification systems in the provinces being compared were the same, premiums in each province would be different. An underlying reason is that territory is always a variable and territorial differences affect premiums. The impact of territorial differences not only helps to explain why premiums in Victoria are different from premiums in Ottawa and why premiums in Dauphin, Manitoba are different from those in Kenora; it also explains why premiums in Kenora are different from premiums in Toronto and perhaps more significantly why premiums in Victoria are different from those in Vancouver.

Territorial differences give rise to differences in accident frequency and accident severity. Accident frequency and severity are affected by factors such as geography and traffic density. Accident severity is also affected by provincial compensation laws. Differences in accident frequency and accident severity in different areas mean that average claims costs in those areas will also be different. Insurers quite legitimately look to their actual losses or claims costs to predict their future losses and thus to set their premiums. If average claims costs in Ontario are higher than, for example, in Saskatchewan, it is reasonable and to be expected that premiums in Ontario will also be higher.

Thus, any assessment of interprovincial premium levels must include an assessment of average claims costs in each of the provinces. The measure used by insurers to assess their actual losses or claims costs in any given territory is called the pure premium or the average loss

cost per car insured. The pure premium is the total claims costs inclusive of adjustment costs divided by the number of insured vehicles. The pure premium provides an assessment of what has actually happened in a particular jurisdiction as measured by total loss costs per car insured. From that perspective, the pure premium calculation demonstrates what premium was actually required, albeit with the benefit of hindsight, just to pay losses and loss adjustment expenses. Operating expense, profit, if any, and investment income are not included in the calculation.

TABLE 15.1

PURE PREMIUM (Loss Costs)

	1986	1985	1984	1983
British Columbia	388.11	359.21	365.15	350.00
Saskatchewan	N/A	227.49	188.81	182.36
Manitoba	332.15	279.37	261.86	255.92
Ontario	443.32	414.31	361.95	315.36
Kenora Region	293.02	302.41	273.49	335.80
Toronto	560.04	511.35	448.44	388.62
Ontario Farmers	253.00	240.66	203.77	254.74
Canada Urban	431.17	396.84	344.97	310.25
Canada Rural	320.73	295.45	258.76	240.88

Table 15.1 shows the pure premiums in Ontario, the three western provinces with public plans and Canada (excluding the provinces with public plans) for the years 1983-1986. For Ontario, the pure premium in the Kenora region,[9] Toronto and for Ontario farmers is shown separately.[10]

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[9]The Kenora Region includes the cities of Kenora and Thunder Bay.

[10]Even these comparisons are not exact since basic coverage is in each province different to some extent; and in the case of Saskatchewan, indirect estimates had to be made due to the lack of reported data.

A number of important conclusions can be drawn from Table 15.1. They include the following:

(1) Territory, even within one province, may have a substantial effect on the pure premium. For example, the pure premium in Kenora between 1983 and 1986 was significantly less than the pure premium in Toronto, and for that matter for Ontario as a whole;

(2) the 1985 pure premium in Saskatchewan was approximately equivalent to the 1985 pure premium for Ontario farmers;

(3) the pure premiums in Ontario and British Columbia in 1984 were approximately the same. By 1986 the pure premium in British Columbia showed only a modest increase over the 1984 figure. By contrast, the 1986 pure premium in Ontario was substantially higher than it was in 1984 and accordingly is considerably higher than the 1986 British Columbia figure; and

(4) throughout the period 1983 to 1986, the pure premium in Toronto has been significantly higher than in any of the other regions being compared.

If the pure premium is higher in one province (or territory) than another, it should surprise no one that the premiums paid by motorists in that province (or territory) are also higher. It might be suggested that the reason the pure premium is lower in the western provinces is that public automobile insurance is more efficient than automobile insurance which is delivered by the private sector. The comparative cost efficiency of public and private automobile insurance which in my view is a crucial consideration will be analyzed later in this

chapter. For the purpose of assessing the usefulness (or otherwise) of premium comparisons, I think it is sufficient to note there is little scope in the pure premium calculation for distortions on the grounds of efficiency. The only part of the pure premium calculation that might be affected by efficiency considerations is claims adjustment expenses and that item in Ontario only accounts for approximately 11% of the premium dollar. In general then, differences in loss costs will inevitably give rise to justifiable differences in premiums. These premiums differences are to be expected. They will continue to exist whether or not Ontario implements public automobile insurance.

It is unnecessary to examine microscopically the reasons why loss costs are higher in one territory than another. Factors such as geography, traffic density and the mix of high risk and low risk drivers all affect accident frequency and severity, and thus loss costs. Loss costs also reflect relevant provincial compensation laws. On this issue, I think it is fair to say that Ontario's compensation laws, particularly taking account of gross-up, family law claims and prejudgment interest, produce more generous tort awards than in British Columbia, Manitoba and Saskatchewan.[11]

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[11]Ontario is the only province of the four in which the principle of gross-up is recognized and applied on awards for future care costs in personal injury cases. Only Ontario and Manitoba recognize the statutory right to compensation on the part of dependents for the loss of guidance, care and companionship. (S.M. 1980, c. 5, S. 4(4). The Manitoba courts have expressed a desire to keep damages for loss of guidance, care and companionship at a modest level. See Laurence v. Good, [1985] 4 W.W.R. 652 (C.A.) which indicated that such an award should be around $10,000 and Larney v. Friesen, [1986] 4 W.W.R. 467 (C.A.).

(b) Cross-Subsidization in Premium Rating

Even if the classification system used by each province were the same, territorial differences and thus differences in loss costs make interprovincial premium comparisons a risky and difficult venture at best. The second and perhaps more serious problem with these premiums comparisons is that the classification systems are not the same. The classification systems used in the public plans involve extensive cross-subsidization. The existence of cross-subsidization fatally flaws any premium

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It should be noted that although British Columbia does not statutorily recognize a dependent's right to non-pecuniary damages for loss of guidance, care and companionship, the B.C. courts have allowed compensation for these losses in limited circumstances. See Jesselson v. Waters, [1981] 27 B.C.L.R. 191; and Sharp-Baker v. Fehr (1982), 39 B.C.L.R. 19.). Manitoba did not recognize prejudgment interest on tort awards until a statutory amendment in 1986. (Judgment Interest and Discount Act, S.M. 1986, c. 39. The statute provided for prejudgment interest on unsettled claims as of October 31, 1986. The M.P.I.C. established a $5.3 million liability for prejudgment interest on outstanding claims to October 31, 1986). Ontario has recognized prejudgment interest on tort awards since 1977. (See Chapter 10. British Columbia and Saskatchewan also have statutory provisions for prejudgment interest. See in British Columbia, the Court Order Interest Act, R.S.B.C., c. 76 as amended by S.B.C. 1982, c. 47; in Saskatchewan see The Pre-Judgment Interest Rate Act, S.S. 1984-1986, c. P- 22.2.) It would also appear that the Crown corporations in the western provinces are much less generous in the payment of party-and-party costs to successful claimants than are Ontario's automobile insurers. For example, I was told that the M.P.I.C. would likely pay between $1,500 to $2,000 for costs on a $50,000 claim. In Ontario, a claimant with a $50,000 claim might expect to receive between $6,000 and $7,500 in party-and-party costs.

comparisons between those provinces with public plans and Ontario.

When premiums are set in accordance with sound insurance principles, cross-subsidization does not occur. In principle, the premium charged for an insured's automobile insurance coverage should reflect the insurer's expected losses. This is generally the basis upon which premiums are set in the private sector. In a competitive environment, no insurance company can offer average prices to the public and stay in business. Professor Booth gives a simple illustration to demonstrate why this must be so.[12] Suppose for example, insurance company X decided that an average risk warranted an average premium of $300. Suppose insurance company Y could divide these risks more accurately into a high risk group that warranted a premium of $400 and a lower risk group that warranted a premium of $200. In this example, Y would be able to sell automobile insurance to the low risk group at $200, but not to the high risk group at $400, because the latter group would go to insurer X and get coverage at $300. Over time, the low risk group would go to Y and be charged a premium in accordance with its risk; the high risk group would go to X where it would be getting "cheap" insurance. Insurer Y would be financially sound since it is pricing its insurance fairly, relative to its expected loss costs; X would lose money since it would be setting premiums on the basis of an average risk when its insureds consisted only of high risks.

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[12] Inquiry Research Study II.

In a competitive industry, the subsidization of higher risks by charging more to lower risks cannot subsist. Premium pricing in the residual market (the Facility Association) represents an exception to this proposition. There is no competition in the residual market. Insurers pool losses and must provide insurance to those insureds who cannot obtain coverage elsewhere. In Ontario's Facility Association, premiums are set at levels lower than justified by expected loss costs.

Apart from the Facility Association (which represents a non-competitive market), in a competitive market, insurers seek to define risks as accurately as possible. This search for the effective classification of risks leads to a complex structure for risk-rating. The classification system and insurer underwriting practices will include a number of relevant variables.[13] The process of identifying and classifying risks is relatively costly, but it has beneficial consequences. One consequence is that an insured pays a premium which reasonably accurately reflects the insurer's expected loss costs on the policy. Another consequence is that insureds have an incentive to change their driving behaviour in order to become part of a lower risk group and thus pay a lower premium; for the very high risk drivers, the premium levels may actually preclude them from driving. Further, private insurers have an incentive to innovate, to seek new ways of classifying individual insureds more effectively or to find new rating variables. While it is an insurer's interest to refine its rating system, it

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[13] For a detailed discussion of the classification system, see Chapter 6.

works to the advantage of the consumer who by this refinement process secures the benefit of a lower premium.

In contrast to a competitive environment, a public monopoly automobile insurer can operate with any rate structure it chooses without fear of providing a competitor with an advantage. All three public plans in western Canada use relatively simple rating structures which result in extensive cross-subsidization. This explains why none of the public plans can permit private sector competition. If the private sector was allowed to compete, then just as insurer Y in Booth's example, it would insure all of the good risks which are overpriced in the public system, leaving the latter with the under-priced bad risks. This point was recently made in blunt terms by the Minister in the Manitoba Government formerly responsible for the M.P.I.C.. During a visit to Toronto last summer, the Minister was reportedly asked "If you are so good at this why don't you become licensed in Ontario and service the Ontario market?" His answer was direct. He said, "Oh, we couldn't do that because we would end up with all the bad drivers".[14] The Minister is correct. If the M.P.I.C. were to move into Ontario and compete with the private sector one of two things would have to occur: the M.P.I.C. would either have to refine its classification system or lose all of its good business to the private sector.

As stated, cross-subsidization occurs with consistency in British Columbia, Saskatchewan and

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[14] TV Ontario transcript - Speaking Out - "Canada's Insurance Industry." (Incident reported by Roy Elms, president of The Royal Insurance Company).

Manitoba. Young drivers are the most obvious beneficiaries of cross-subsidization. Young drivers present in relative terms the same risk to the public insurance systems in British Columbia, Saskatchewan and Manitoba as they do to any other insurance system including that in Ontario. Nevertheless, the three public plans in their simplified classification systems have deliberately eliminated age as a rating variable and have not introduced a substitute.[15] This coupled with the fact there is no underwriting discretion exercised in the public plans means age is totally ignored as a rating variable. In practical terms, the result is that young drivers in British Columbia, Saskatchewan and Manitoba pay lower insurance premiums than is actuarially justified, as a matter of social policy, not insurance principles. This inevitably means other drivers in the system pay more than is justified by the application of sound insurance principles.

The I.C.B.C. Auto Plan which has a more complex classification system than either Saskatchewan or Manitoba now uses five rating variables--value and age of the car; the territory where the insured vehicle is principally operated;[16] the purpose for which the vehicle is used; the claims record of the owner; and a driver insurance premium based on the individual's driving record.

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[15]Ontario is about to eliminate age in its classification system, but it is essential to recognize it has introduced year licensed as a substitute.

[16]Attempts, as yet unsuccessful, have been made to legislate away this territorial distinction.

Before 1980, the I.C.B.C. also rated on the basis of age, sex and marital status. In 1979, the British Columbia Government made a decision to eliminate age, sex and marital status as rating variables; no substitute rating factors were put in their place. Instead, the I.C.B.C. introduced its FAIR programme, together with a Claims-Rated Scale. The FAIR programme operated on the basis that individual motorists regardless of age, sex or marital status should be treated as innocent (a safe driver) until proven guilty (an unsafe driver), a notion which defies sound insurance principles. The Claims-Rated Scale, a type of bonus-malus system is used to apply a discount or surcharge to the basic premium on the basis of the insured's driving record.[17]

The classification systems used by Saskatchewan's Auto Fund and Manitoba's Autopac are much simpler than that of the I.C.B.C. S.G.I. charges a standard premium for third party liability and no fault accident benefit coverage as well as a premium to cover all perils damage to the insured's car which varies in accordance with the value of the car. Surcharges are levied based on the individual's at-fault accident history and driving record over the previous three years.

The M.P.I.C. eliminated age, sex and marital status as rating factors in 1986. Premiums are based on the type and principal use of the car, with surcharges levied in accordance with a schedule of demerit points.

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[17]The scale gives a 10% discount each claim-free year up to a maximum of 4 years or 40% and a 30% surcharge for each claim.

It is obvious that in all three public plans high risk groups are being subsidized by low risk groups. Young drivers will certainly find automobile insurance far less expensive under all three public plans because of cross-subsidization. In Saskatchewan, because territory is ignored as a rating factor, rural drivers are subsidizing city drivers.[18] In Saskatchewan and Manitoba because of the very simple classification system employed by the S.G.I. and the M.P.I.C., cross-subsidization is extensive; even in British Columbia, it is considerable. Still, since there are relatively fewer of these high risk drivers, substantial premium decreases can be obtained for high risk groups with only moderate "excess" premium payments by the rest of the driver population.

Quebec should not be ignored in any discussion of cross-subsidization. All insured motorists in Quebec pay the same premium for compulsory coverage provided by the Régie. This results in massive cross-subsidization.[19]

For present purposes, I emphasize the existence of cross-subsidization in British Columbia, Saskatchewan and Manitoba only to illustrate how misleading it is to compare premium levels in the three western provinces and Ontario. If a young driver in British Columbia, for example, is paying an automobile insurance premium 50% less than is actuarially justified, is it reasonable to compare that insurance premium with the same young

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[18] This assumes that Saskatchewan rural drivers like rural drivers in Ontario are less of a risk than city drivers.

[19] Professor Gaudry has commented on this issue in analyzing the accident rate in Quebec. See Inquiry Research Study I.

driver's premium in Ontario, where the young driver will be paying what his or her expected lost costs indicate should be paid? The answer to that question is obvious. For the purposes of an intelligent debate as to the desirability of introducing public automobile insurance, interprovincial premium comparisons are at best unhelpful and at worst, misleading.

There is a final observation to be made. In the past few months, all three public plans have announced substantial premium increases.[20] If nothing else, these increases render the premium comparisons submitted during the course of the Inquiry, non-current. These premium increases are an affirmation of a fundamental business principle; no insurance system can indefinitely pay out more than it brings in. In a public delivery system, if costs exceed revenues either premiums or taxes have to increase.

In my view, the relevant issue is not what a particular class of driver might pay in Toronto as compared to Regina or Victoria; rather, the relevant issues are:

(a) whether costs and thus premiums can be reduced by adopting public automobile insurance; and

(b) even if there are no cost efficiencies, whether there are social benefits favouring a public over a private delivery system.

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[20] Globe and Mail (November 21, 1987); Toronto Sun (January 3, 1988).

E. PUBLIC VERSUS PRIVATE DELIVERY-- SOME GENERAL CONSIDERATIONS

In one sense, the debate is over a question of political and social values. Whether to have a public or private delivery system reflects on the part of many, their philosophical belief as to whether or not the society in which they live will be better off by nationalizing an important service industry. In this context, although not determinative of the issue, I think it is fair to recognize that Ontario has had a long history of a free market economy. A philosophy of free enterprise continues to be accepted by a large proportion of the population of this province.

Whatever one's philosophical perspective, there are consequences of a decision to nationalize Ontario's automobile insurance industry which cannot be lost sight of in the debate. One obvious consequence is that there will be very significant financial and organizational implementation requirements. Measured by direct premiums written in 1986, the Ontario operations of one insurer, the Co-Operators, are larger than the entire M.P.I.C./Autopac, and yet the Co-Operators has less than 10% of the Ontario market. The four leading insurers in Ontario - Co-Operators, State Farm, Royal Insurance, and the Economical Group - which together have only about 27% of the Ontario market, wrote more automobile insurance business in Ontario in 1986 than the I.C.B.C.[21] I mention

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[21] See Inquiry Research Study II. See also Canadian Insurance, 1987 Annual Review of Statistics. M.P.I.C./Autopac gross premiums in 1986 were $223,209,000. Co-operators wrote $279,167,000 in direct premiums in Ontario in 1986. The I.C.B.C. net premium earned figure

this simply to illustrate that the undertaking is a sizeable one. Implementation costs will be substantial.

The impact of government ownership on the lives and jobs of all those employed in the automobile insurance industry--company employees, brokers, agents and adjusters--must be taken into consideration. Undoubtedly, a provincial Crown corporation would employ or use the services of a substantial number of those now working in the private sector. Yet some employees would lose their jobs; others to retain theirs would have to face the prospect of relocating themselves and their families, because it is likely that the establishment of a Crown corporation will result in a more centralized insurance operation than now exists. If efficiency gains are looked to as a justification for public automobile insurance it seems to me the operation would have to be centralized, probably in Toronto.

Nor can one ignore the potential impact of Ontario government ownership of Ontario's automobile insurance industry on the Canadian automobile insurance industry and on the general insurance industry in this province.

Ontario is clearly the dominant automobile insurance market in Canada. Automobile insurance in this province accounts for an estimated 50% of the total Canadian automobile insurance business of private insurers. Excluding the private sector from all or virtually all of

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in 1986 was $757,754,000. The leading four insurers in Ontario together wrote $844,658,000 in direct premiums in 1986.

the Ontario market[22] may limit industry involvement in the remainder of the Canadian market.

Automobile insurance also accounts for nearly half of the total general (other than life) insurance business in Ontario. If the delivery of automobile insurance was made public, then it is quite possible that general insurance companies which will rely on automobile insurance for a significant share of their business could withdraw from the Ontario market altogether. Such withdrawals would not only have adverse employment effects, but might well create a shortfall of capacity in general insurance lines. The potential of this withdrawal is, I concede, somewhat speculative.

A government-run insurance corporation is the most drastic response to a call for greater government intervention in the automobile insurance industry. If the performance of the private delivery system is ineffective or inefficient to a degree that demands government involvement, then other measures falling short of nationalizing the industry must also be considered. Rate regulation in the form of the establishment of a rate review agency or even a rate setting agency is one alternative.

I raise all of these concerns because, in my opinion, they are important and ought not to be ignored. In and of themselves, they should not preclude the adoption of a public plan if the merits of government ownership can be

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[22] The private sector may be allowed to compete on optional coverage as in the public plan.

clearly demonstrated. However, these concerns suggest to me that before Ontario completely abandons its present private sector competitive structure, there ought to be a clear and convincing case in favour of public automobile insurance.

F. PUBLIC VERSUS PRIVATE DELIVERY-- ADVANTAGES AND DISADVANTAGES

The adoption of a public plan would involve two changes from the present delivery system in Ontario. There would be a change in ownership from a private corporation to a provincial Crown corporation and there would also be a change in market structure from a competitive environment to a monopoly.

In theory, it would be possible to permit private sector insurers to compete head-on with the Crown corporation in the delivery of automobile insurance. This could but will not happen, judging from the experience of provinces with public plans, and having regard to the inevitable consequences of competition between a public plan and the private sector. If a public plan were to adopt the simplified rating practices characteristic of the I.C.B.C., the M.P.I.C. and the S.G.I., as earlier stated, the private sector would secure the business of all overpriced risks and cede the high risk business by default to the competing public plan. In the end result, the public plan would be insuring average and below average risks at average premiums; the private sector would be insuring better than average risks at average premiums. The private sector would thrive; the public plan would eventually wither.

It is not a coincidence that the legislation establishing the public plans in Quebec, Manitoba, Saskatchewan and British Columbia precludes private sector competition. There may be a number of reasons for this; clearly one reason, however, is that the public monopoly insurers could not withstand private sector competition. If the public plan were to refine its rating practices to avoid the inevitable loss of low risk business to the private sector, true competition would exist. The public plan, however, could no longer claim the public relations benefit of presuming certain risks were good risks until an event (e.g., an accident or a conviction) proved otherwise.

I consider the two basic choices to be retention of the present competitive private sector delivery system on the one hand and the establishment of a public monopoly on the other. If the choice is to retain the present system, then lesser forms of government intervention--rate review or rate setting--must also be considered.

(a) Cost Efficiency

Of all the considerations that might be brought to bear on the debate over public and private automobile insurance, in my opinion the critical consideration is cost efficiency. To put it another way, absent demonstrable efficiency gains, the case for public automobile insurance is severely compromised.

The public's interest in this issue is premium-related. Can automobile insurance be delivered at less cost by the government than by the private sector? Will public automobile insurance lead to lower premiums

for the consumer? These are the dominant questions to be answered. Answers to these questions cannot be found by comparing premiums in Ontario with premiums in jurisdictions having public plans.

An assessment of cost efficiency requires consideration of economies of scale, the probability of claims or operating expense reduction and the benefit, if any, to be derived from the elimination of private sector profits. In making this assessment I have taken account of available data from all three public plans. I regard the I.C.B.C. experience to be the most relevant for assessing the probable consequences of government ownership of automobile insurance in Ontario. While I have not ignored the M.P.I.C. or the S.G.I., the size of the I.C.B.C. and the greater statistical disclosure provided by it make the British Columbia experience more useful.

(i) Economies of Scale

The advantage of size is what economists refer to as economies of scale. The Halpern study gave careful consideration to this issue and concluded that there are no significant economies of scale in the writing of automobile insurance.[23] I agree with that conclusion but subject to certain qualifications. In making a theoretical comparison between major Ontario insurers and an Ontario public automobile insurance corporation, there will be no efficiency gains attributable to economies of scale (size). It is obvious that some of the smaller

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[23] See Inquiry Research Study II.

insurers in the Ontario market are too small (in the economic sense) and accordingly cannot realize those efficiency gains which result from economies of scale.

(ii) Expense Efficiency

Table 15.2 provides an expense breakdown for the three public plans for the period 1982-86 and for Ontario for the period 1982-85. The expense ratios reflect both the fixed and variable costs of writing automobile insurance. They include claims adjusting expenses (fees paid to adjusters, lawyers, etc.), commissions paid to brokers and agents, and other operating expenses. As Halpern notes, in identifying expense ratios for automobile insurance alone there is difficulty in allocating common costs for private sector insurers or public plans that engage in other lines of insurance. Allocations may sometimes be arbitrary. Halpern gives as an example the administration (operating) expense ratio in Saskatchewan which dropped 4.7% from 1982 to 1983 while the opposite movement occurred in that element of the expense ratio in Saskatchewan's general insurance operations.

Another difficulty in looking at expense ratios is that the ratio takes both expenses and premiums into account. The expense ratio can be improved (lowered) by reducing expenses and by increasing premiums or both. Halpern suggests that over the period being considered in Table 15.2, Saskatchewan premiums were too high with the result that Saskatchewan expenses as a percentage of

TABLE 15.2

EXPENSES AS A PERCENTAGE OF EARNED PREMIUM: AUTOMOBILE

	1986	1985	1984	1983	1982	Average 1982-1986
ICBC[24]						
Claims Adjusting	9.3	8.7	8.8	9.1	9.5	9.1
Administration	7.8	7.8	8.8	8.8	8.4	8.3
Commission	7.5	6.8	6.7	5.9	6.2	6.6
TOTALS	24.6	23.3	24.3	23.8	24.1	24.0
MPIC						
Claims Adjusting	11.8	10.8	10.5	10.3	9.9	10.7
Administration	4.3	3.6	4.2	4.9	4.4	4.3
Commission	4.7	4.7	4.5	4.8	4.9	4.7
Premium Taxes	3.0	3.0	3.0	3.0	2.7	3.0
TOTALS	23.8	22.1	22.4	23.0	21.9	22.7
SGI						
Claims Adjusting	8.5	8.5	8.5	8.5	8.5	8.5
Administration	7.6	9.8	6.2	6.3	11.0	8.2
Commission	0.9	1.2	0.8	0.9	0.8	0.9
Premium Taxes	4.0	4.0	4.0	3.3	3.0	3.7
TOTALS	21.0	23.5	19.5	19.0	23.3	21.3
ONTARIO[25]						
Claims Adjusting	11.0	11.0	11.0	11.0	11.0	11.0
Administration	7.0	9.4	11.1	10.9	10.5	9.8
Commission	11.4	11.5	11.3	10.8	10.4	11.1
Premium Taxes and Licence Fees	3.4	3.4	3.4	3.4	3.4	3.4
TOTALS	32.8	35.5	36.8	36.1	35.3	35.3

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[24] The I.C.B.C. did not pay premium taxes in the years being compared. It now does pay this tax.

[25] The Ontario claims adjusting expense ratio has been estimated at 11.0%. While not precise, this figure is generally thought to be reasonably accurate.

earned premiums were low.[26] Although I view resort to comparing expense ratios as a precarious exercise it does serve to illustrate the expense-related differences between the public plans and Ontario. Subject to the general concerns expressed above, these conclusions may be taken from Table 15.2:

(1) Commission costs in Ontario are substantially higher than commission costs in the public plans. The Ontario average figure of 11.1% is considerably above the averages for the I.C.B.C. of 6.6%, the M.P.I.C. of 4.3% and S.G.I. of 0.9%;

(2) The claims adjusting ratio in the public plans varies between 8.5% and 11.8%. The Ontario claims adjusting ratio of 11.0% is within that range. The average claims adjusting ratio for each of the public plans is slightly below that of Ontario. Halpern observes that the differences could be accounted for by the 1.3% allocation of corporate overhead included in the Ontario figure; and

(3) Ontario insurers' administration (or operating) expenses of 9.8% are clearly higher than the averages for the I.C.B.C. of 8.3%, the M.P.I.C. of 4.3% and S.G.I. of 8.2%. This item includes all expenses other than claims adjustment

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[26] See Inquiry Research Study II. Another illustration can be seen in the administration or other operating expense ratio for Ontario for 1985/86. The decline in that ratio from 11.1 in 1984 to 9.4 in 1985 and to 7.4 in 1986 is no doubt largely, if not wholly, attributable to the 1985/86 premium increases. To have any real validity, expense ratios should be considered over a five-year period.

expenses and commission (a part of operating expenses dealt with separately in Table 15.2). Part of the differential must be attributable to lower underwriting costs in the western provinces. For example, the public plans do not make a direct payment for motor vehicle record searches. Ontario insurers pay a $5 fee per search.

There appear to be two main reasons for the difference in total expense ratios between Ontario and the public plans: commissions and other operating expenses. There is no cost savings in claims adjusting expense of any real consequence, particularly if the arbitrary Ontario head office allocation is taken into account. Even without that adjustment, claims adjusting expense differentials are relatively small.

Commission costs or business acquisition costs in the public plans are lower than in Ontario. There is no uncertainty about this. The commission structure for broker companies in Ontario is a cost of competition. Whether it is a reasonable cost is something that need not be debated here. Brokers provide the link between consumers and insurers. Insurers have to provide a commission-based incentive to secure business through a broker. An insurer paying a lower rate of commission will inevitably see its market share decline. Direct writers are exposed to lower direct business acquisition costs than insurers who rely upon independent brokers. But direct writers are exposed to indirect business acquisition costs in that they must establish a corporate identity or market recognition. Thus, all private sector insurers face business acquisition costs that are not

duplicated in public monopoly plans. This is not a public-private issue, but rather, a product of monopoly as opposed to competitive delivery.

It can be said that brokers and agents perform services for their clients that are unnecessary in a public monopoly. These services include providing information on the coverages offered by different insurers and shopping the market for better rates. Some, including Halpern, suggest that higher commissions are paid in Ontario than in the public plans because Ontario brokers perform these additional services for their clients. I tend to disagree with this way of looking at the matter. The real reason for the existing commission structure, is as I have said, that insurers have to provide an incentive to obtain business.

Once broker commissions are separated from operating expenses as they have been in Table 15.2, conclusions about differences in other operating expenses must remain somewhat uncertain and guarded for the following reasons:

(a) Operating expense (less commissions) expressed as a percentage of earned premiums is susceptible to distortion because of changes on the premium side. Unlike commissions which directly vary with premiums, a large part of operating expense is fixed;

(b) For those automobile insurers also engaged in non-automobile lines of insurance (this includes the M.P.I.C., the S.G.I. and most of Ontario's private insurers) allocation of operating expense, even if done with the best of intentions, may be somewhat arbitrary. It has

> been suggested by some that fixed operating expenses are vulnerable to manipulation. The potential for manipulation exists in both public and private sector operations; the real potential for manipulation is significantly less in the private sector because of the number of insurers that would be required to participate to effect a significant data change. I have no evidence of manipulation of operating expense and, therefore, decline to base any conclusions on the mere prospect of it having occurred.

One plausible explanation for at least part of the difference in operating expense is that the public plans use a simple classification system and perform no underwriting functions. Private Ontario insurers, in order to compete effectively, are required to engage in more complicated risk rating. This is an additional cost to the Ontario delivery system. I have no evidence to indicate what that additional cost might be. Intuitively, I expect it is not overly significant. Whatever it may be, once again, this is not a public-private issue. The costs savings to the public plans resulting from the use of simpler rating structures is directly attributable to the fact these plans are monopolies.

Whether one calls them efficiency gains or not, it is undeniable that public monopoly automobile insurance can achieve cost savings when compared to a competitive automobile insurance industry in the private sector. The most important cost savings is lower business acquisition costs (mainly broker commissions); a less significant cost savings is in other operating expense. These cost

advantages depend not on the difference between public and private delivery, but on the difference between monopoly and competitive delivery.

Apart from the monopoly-related cost savings just discussed, I do not think it can realistically be asserted that public plans have found some particular method to write automobile insurance in a more "efficient" way than private insurers. This observation is reinforced by an examination of the performance of the public plans in non-automobile insurance where they must compete with the private sector. Both the M.P.I.C. and the S.G.I. compete with private insurers for general insurance business; the I.C.B.C. also competed until it sold its general insurance division in 1985.

Table 15.3 shows the expense ratios for the M.P.I.C., the S.G.I. and the I.C.B.C. in their general insurance operations for the 1982-86 period. The general insurance expense ratios are dramatically different from the corresponding automobile expense ratios. The M.P.I.C., for example, has a total expense ratio in its general insurance division in each year considered which is double the automobile total expense ratio in 1986 and more than double in every other year.

What is perhaps more instructive is that the apparent strength of the public automobile insurance plans in having low administration and commission expense ratios disappears in their general insurance operations. It is obvious that the commission expense is higher because the public plan has to compete for business in its general insurance division. Booth also notes that the

TABLE 15.3

EXPENSES AS A PERCENTAGE OF EARNED PREMIUM: GENERAL INSURANCE

	1986	1985	1984	1983	1982
MPIC					
Claims Adjusting Ratio	5.0	5.9	4.1	4.1	4.3
Administration Ratio	18.0	19.8	15.5	14.8	16.3
Commissions	18.3	19.7	20.7	24.9	24.9
Premium Taxes	4.6	4.7	3.1	2.9	2.2
TOTAL	45.9	50.1	43.4	46.7	47.7
SGI					
Claims Adjusting*	N/A	N/A	N/A	N/A	N/A
Administration Ratio	N/A	15.9	16.9	17.7	11.0
Commissions	N/A	19.4	19.1	18.7	19.0
Premium Taxes	N/A	4.3	4.6	3.9	3.3
TOTAL	39.6	40.6	40.3	34.1	
ICBC					
Claims Adjusting*	N/A	N/A	N/A		
Administration	19.0	19.8	21.0		
Commissions	22.5	21.7	18.9		
Premium Taxes	3.2	3.2	3.2		
TOTAL	44.7	44.7	43.1		

*Not broken out with claims costs.

non-automobile expense ratios of the public plans compare unfavourably with the non-automobile expense ratios for the private sector. I do not think it is fair to draw any efficiency conclusions concerning the general insurance operations of the public plans. But I think it is fair to conclude that these public monopolies have not discovered

any method of controlling expenses which if imported to Ontario would allow them to out-compete private insurers. In other words there is nothing to suggest that any of the public plans have unearthed any operational secrets which would permit them, if faced with private sector competition, to prosper and thus offer lower premiums to the consumer.

Although a public plan in Ontario could not lay claim to cost efficiencies if faced with competition, it is nevertheless clear that public automobile insurance, at least in the short term, if given a monopoly position would be exposed to lower costs than the private sector insurers. In making this statement I am ignoring the start-up costs of a public plan, which in Ontario would be enormous. If a public automobile insurance plan is introduced in Ontario and is given a monopoly position, it is reasonable to proceed on the assumption that the cost savings will approximate those in British Columbia.

As previously indicated, the principal source of these cost savings is commissions. For the purpose of analysis, if the commissions in Ontario were reduced to British Columbia levels, savings in the range of 4-5% would result. If this was the only area of savings and if the resulting cost reductions were translated directly into premium reductions, then premiums for Ontario motorists would be reduced by approximately $30 per car.[27]

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[27]This estimate was made by Joe Cheng, the actuary retained by the Inquiry, using I.B.C data. Cheng used an Ontario average weighted premium of $500 and an expense ratio (exclusive of claims adjusting expense) of 25%. The figure of $30 is within the range calculated by Booth (See Inquiry Research Study II). It should be made clear that

There may be other potential areas of savings but they are small. One, however, is visible. That is the cost savings that would result if the monopoly insurer were to use a simplified classification system and were to virtually eliminate underwriting-related expenses. It is impossible to proffer anything other than a speculative estimate of these cost savings. Again, looking to British Columbia, it appears to me that at most, there could be additional cost savings of 3%.[28]

As I see it, even based upon a costless conversion to public delivery, the maximum premium reduction that could be achieved by the monopoly insurer would be approximately $43 per car.[29] Part of this cost and premium reduction is only achieved by abandoning Ontario's relatively complex system for classifying and underwriting risks. It should not be forgotten that the beneficiaries of that system are low risk drivers. The beneficiaries of the conversion to an I.C.B.C. classification system will be high risk drivers. Because of the change in the classification

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this calculation does not indicate who is going to benefit from the premium reduction. The impact of the cost savings on premiums in a public plan is an entirely separate issue considered later.

[28]Table 15.2 indicates a difference in average expense ratios between British Columbia and Ontario of about 8% of which 4-5% is accounted for by commissions. Premium taxes (now paid by the I.C.B.C.) and licence fees have been held constant. Booth's results are roughly similar, save that Booth places more emphasis on the savings from using a simple classification system than I do. This goes, however, to the source of the savings, not its quantum.

[29]Cheng estimated that a 7% expense saving translated into an average premium reduction of $43 per car.

system, the impact of the aggregate cost savings will affect different insureds totally differently. Young (or inexperienced) drivers, for example, will enjoy massive premium reductions. According to Booth's study with which I generally agree on this point, approximately 43% of Ontario's drivers who are now classified as low risk drivers will face premium increases of about $55.

These cost calculations have been derived by comparing the actual British Columbia and Ontario experience, an approach which is designed to estimate the maximum potential cost savings achievable by conversion to a public monopoly. The exercise undertaken thus far is helpful as a starting point. In order to provide a realistic assessment of the probable cost consequences of conversion to public monopoly automobile insurance it is essential to take account of a number of considerations thus far ignored. All go to reduce, if not eliminate entirely, the potential for cost saving. They include:

(1) Start-up costs of a public insurance corporation must be set off against any gross cost saving estimate. This has to be a massive undertaking which inevitably would dwarf even the I.C.B.C. in size. An Ontario public insurance corporation would write more than ten times as much business as Ontario's largest private insurer. This is not the case of renting three floors in an office building in Mississauga. Even if existing facilities are used, office space will represent a cost to the system. So will personnel, and claims and administrative offices that must be established throughout the province. Although the Ontario operation will

be substantially larger than that of the I.C.B.C. one cannot help recalling the transfer to the I.C.B.C. of $175 million in 1977.[30] I mention this transfer (which in current dollars would likely be doubled in amount) not because it has not been paid back, but because it had to be paid in the first place. I received no evidence as to what the reasonable start-up costs might be, but no one could seriously dispute the suggestion that start-up costs for a public automobile insurance corporation in Ontario would be enormous. Whatever the start-up costs are, they will be reflected in increased automobile insurance premiums or increased taxes or both.

(2) Monopoly delivery by definition forecloses access to the benefits of competitive pricing. The same incentive to keep premiums low does not exist. The impact of this factor is unquantifiable.

(3) If the public monopoly adopts a simple classification system as has been done in all public plans in Canada (to varying degrees) demonstrably high risk drivers will pay substantially lower premiums than otherwise would be the case. When this happens, as the Quebec experience indicates and Professor Gaudry's study confirms, there will be more high risk drivers on the road and there will

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[30] Insurance Corporation of British Columbia, Comparative Aspects of the Insurance Corporation of British Columbia and Private Sector Insurance Companies in Canada (Vancouver: The Corporation, 1985), p. 8.

inevitably be an increase in accident frequency and severity. Increased claims costs will result which will reduce, if not eliminate, the theoretical cost decreases in operating expense discussed earlier.

(iii) The Profit Argument

Many who support public automobile insurance suggest that private insurers are making substantial profits which would be eliminated under a public monopoly with the result that consumers would benefit by having lower premiums. The argument is that any profits made by Ontario automobile insurers would be transferred to Ontario motorists. That argument is fundamentally flawed. Without the ability to make a profit, private insurers would not be in business. If they went out of business, the public would be denied the benefit of lower premiums which results from competition.

Some critics of Ontario's private insurers are fond of quoting the alleged profits made by the insurance industry as some evidence that the Ontario driving public would be better off with public insurance. I hold no brief for the insurance industry and as other parts of this Report have indicated, there is much about the private sector delivery system to be criticized. But statements such as "the insurance industry made $2 billion last year" add nothing to the debate. Such statements ignore the fact that there are different lines of insurance and some may be profitable while others are not, ignore the number of individual insurers, ignore provincial boundaries and most importantly ignore the fact that companies in a competitive industry are entitled to

make a profit. Automobile insurance should be looked at on its own. If there are excess profits in other lines of insurance, that is an issue which should be separately considered.

On the profit issue, in my view, the only relevant question is whether Ontario's insurers are making monopolistic or oligopolistic profits from their automobile insurance operations. The available evidence strongly suggests, at least in the last several years, that there are no "excess" profits in this business.

The analysis of premium levels and loss costs which is contained in Chapter 7 makes it abundantly clear that the premiums charged to Ontario motorists are consistent with competitive prices and with expected loss costs. This conclusion was also reached by Professor Halpern in his study for the Inquiry. Further, there is no evidence at all of cartel-like or collusive behaviour amongst Ontario insurers which would give rise to excess profits.

While economists suggest that in a competitive industry such as the automobile insurance industry there can be no excess profits, the potential for excess profits is a matter better addressed by rate regulation than by nationalization.

Finally, if contrary to the view I have expressed above, there is any validity to the profit argument, it seems to me that this argument could be used to justify nationalizing any industry that is making a profit. There is nothing peculiar about the automobile insurance industry that makes it particularly vulnerable to the transfer of profit to the consumer argument.

(b) Social Benefits and Other Considerations

(i) Choice and Competition

In the public plans there is, of course, only one supplier of automobile insurance, the monopoly Crown corporation. If a consumer, for whatever reason, is unhappy with the public monopoly, the consumer cannot turn to another supplier of automobile insurance. The choice is simple: deal with the public monopoly or do not drive.

This is not the case in the competitive environment in which private insurers operate. An insured, unhappy with the service or the rates quoted by one insurer has the choice of other insurers with whom he can do business.

Freedom of choice and the benefits of competition are hallmarks of a private enterprise system. I do not regard the matter so much in ideological terms as in practical terms. It seems to me that the freedom to choose from among a large number of competitive insurers is an undeniable advantage to those who are required by law to purchase automobile insurance in order to drive.

(ii) Fairness in Premiums

It is argued by some that the setting of premiums on the basis of an individual's actual driving record rather than his expected risk is fairer and more equitable. The innocent until proven guilty theory of premium setting dominates the public plans. This leads to extensive subsidization of high risk drivers by low risk drivers.

The issue here is whether premium rating will or will not be based on insurance principles.

If such extensive and institutionalized cross-subsidization is seen as a socially desirable policy then it perhaps argues for public delivery. For reasons elaborated upon earlier, such extensive institutional cross-subsidization will not subsist in a truly competitive industry.

I see nothing fair or equitable about a system which generally requires low risk drivers to subsidize high risk drivers. I see nothing unfair or inequitable in requiring any driver, young or old, male or female, married or unmarried, to pay a premium which reflects his real risk to the system as assessed on the basis of sound insurance principles. I acknowledge that a case can be made on social policy grounds for some cross-subsidization of certain groups of drivers. Taxis are an example. If all taxi drivers were required to pay premiums that reflected their expected loss costs, many could not afford to be in business. Modest cross-subsidization can in that event achieve a useful social purpose. It can, however, be effected by the private sector through the Facility Association. In other words, through the use of the residual market; cross-subsidization and private competition can co-exist.

In a competitive private sector market, modest cross-subsidization through the residual market should be viewed as the exception rather than the rule. If cross-subsidization exists in the Facility Association the winners are obviously those drivers who will pay less than actuarially sound premiums. What must not be forgotten is

that the losers are the rest of Ontario's motorists who will be called upon to pay increased premiums. To the extent that the population of the Facility Association expands, the benefits the rest of Ontario's motorists derive from competition, contract. If real competition is to continue it will be necessary to monitor and control the number of insureds in the residual market.

The issue of cross-subsidization should not be confused with the issue of whether age, sex and marital status should be abolished as rating variables. There may be social or constitutional reasons which dictate that insurance premiums not be based on these variables. Their elimination will not lead to any significant degree of cross-subsidization provided they are replaced with reasonably accurate substitutes. One of the main reasons there is extensive cross-subsidization in the public plans is that there are no substitutes in place for age and sex, only surcharges (or discounts) levied after the fact. In addition to the fairness issue, as Halpern notes, cross-subsidization provides a perverse incentive in allowing some high risk drivers on the road who might not otherwise be able to afford insurance. In my opinion, the simplistic classification systems used by the public plans are inequitable. I regard these rating practices as a significant disadvantage of public delivery systems.

(iii) Availability and Affordability

Automobile insurance is compulsory for those who wish to drive. In the public delivery systems, the provincial Crown corporation is obligated to sell insurance to all those who are required to buy it. There is no necessity for a residual market mechanism. Questions of

availability do not arise. In Ontario's competitive industry, no single insurer is required to sell insurance to any particular consumer. In order to ensure the availability of insurance to those required by law to buy it, a residual market is necessary. In Ontario, the residual market is served by the Facility Association. The public delivery system directly and the private delivery system through the Facility Association both guarantee the availability of insurance coverage.

Affordability is another matter. To a large extent it is related to the question of the fairness of insurance rates. The problem is to determine what is meant by fairness. As I indicated in Chapter 12, I approach this matter rather cautiously, going no farther than to indicate that automobile insurance should be made available at a price consistent with proper insurance principles. From this perspective, it would be inappropriate to suggest that a public plan had any advantage over the present private delivery system in Ontario. In any insurance plan, public or private, premiums and investment income have to be sufficient to pay claims and other expenses. There is no magic in public delivery which dilutes this fundamental business principle.

(iv) Compliance

In public plans, the government is responsible not only for the issuance of driver permits and vehicle registrations but also for the issuance, renewal and withdrawal of insurance coverage. In the three western provinces, these systems are integrated. A car owner cannot obtain his licence plates or renewal sticker

without the simultaneous purchase of automobile insurance. This integration provides an effective means of ensuring compliance with and enforcement of provincial compulsory insurance legislation. Some will drive without any insurance in any plan; in the public plans the uninsured driver problem seems to be minimal.

With a private sector delivery system, it may be marginally more difficult to link insurance and licensing requirements, although, I hasten to add, in the computer age one would not have thought it necessary to have a public delivery system to achieve this link up. In principle, vehicle registration cannot be issued or renewed in Ontario without proof of insurance. In practice, information submitted on insurance coverage at the time of registration is not routinely or efficiently checked. In any event, there is no centralized information retrieval system which would allow the licensing authority to confirm the existence of valid coverage. This deficiency ought to be recognized and corrected.

I think it must be conceded that the public plans have done a better job in integrating licensing and insurance requirements than have the Ontario Government and private insurers. But is should also be recognized that the gains to be achieved by such integration are very modest, bearing in mind the fact that current estimates suggest less than 2% of Ontario's drivers are uninsured.[31]

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[31] Care has to be taken in assessing data relating to breaches of the Compulsory Automobile Insurance Act. I regard uninsured motorists as motorists who have no automobile insurance coverage. I do not include drivers who cannot produce the required liability insurance

The integration of licensing and insurance requirements has a dimension to it which goes beyond the issue of compliance. Such integration allows the public plans to give surcharges or discounts to individual drivers based on their driving experience. Driver-based surcharges and discounts promote deterrence and may well be justified in principle on that ground alone. They are not, however, a substitute for a sound classification system. They do lessen, albeit after the fact, the extent of cross-subsidization in the public plans. Furthermore, they likely result in an owner whose vehicle is driven by a high risk occasional driver, paying a lower premium than would otherwise be the case. I consider this capacity to assess the individual drivers to be one of the distinct advantages of public automobile insurance.

(v) Traffic Safety and Accident Prevention

In a public delivery system, the government or Crown corporation should have a strong financial interest in accident prevention. The more accidents that can be prevented the less that is required to be paid out in claims; the less paid out in claims, the less the drain on government expenditures and the more premiums can be reduced. All of this makes good economic and political sense.

Private sector insurers are not naturally in the business of accident prevention and they are unlikely to

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certificate but who are, in fact, insured.

have the same vested interest in promoting traffic safety as a government-run automobile insurer.

Administration of a comprehensive traffic safety program can likely be undertaken more easily and at less cost in the public sector. The province already has various administrative systems in place which affect the driving public. These include driver's licences, vehicle registration and demerit point systems, and O.H.I.P. and related health delivery files. Coordination and centralization of the information flow and administrative requirements for a traffic safety program can be effectively integrated into the existing public sector systems. Gerald Wilde, Professor of Psychology at Queen's University, has written extensively on the topics of accident prevention and the use of incentives for safe driving. In his research study for the Inquiry, Professor Wilde concluded that

> With respect to most criteria, the opportunities for effective safety programming would seem to be greater under public than under private control over automobile insurance.

Among the public plans in Canada, the I.C.B.C. has been particularly active in the area of accident prevention. The I.C.B.C. spends approximately $4 million per year on its traffic safety activities which include both research and planning and the development of educational programs. Several of the programs developed by the I.C.B.C. have been used throughout North America. The I.C.B.C. commitment to accident prevention is clear and commendable. I have not, however, attempted to evaluate the success of the I.C.B.C.'s accident prevention program nor am I aware of any independent

evaluation of it. If one were to assume the I.C.B.C. traffic safety programs have succeeded in reducing accident frequency and severity (a not unreasonable assumption), given British Columbia's increasing bodily injury accident frequency rate, it is unnerving to contemplate what the situation would be without the I.C.B.C. commitment of resources to traffic safety.

I am in agreement that the interest in and opportunities for the promotion of traffic safety are likely to be greater in a public than a private delivery system. Yet the government's interest in traffic safety and its commitment to accident prevention should not depend upon whether it is responsible for the automobile insurance system. Motor vehicle accidents are a serious social problem. They impose a huge human and economic cost on society. Any responsible government should be committed to taking effective measures to reduce motor vehicle accidents whether or not it is in charge of the automobile insurance system.

(vi) Impact on Repair Costs

The Woods, Gordon Report prepared for the 1978 Select Committee on Company Law suggested that one advantage of a public delivery system would be its ability to lower repair costs due to its monopoly power over auto body shops and its research capability into new methods of repair.

The evidence does not appear to bear this out. I dealt with the costs of repairs in Chapter 7. 1986 data show that the cost of labour, shop and paint material in Ontario is substantially lower than in British Columbia,

Manitoba and Saskatchewan. A possible and quite plausible explanation is that body shops in Ontario compete for the business of competing insurers. That seems to have resulted in lower body shop wage rates in Ontario.[32]

(vii) Other Matters

Public plans pay no corporate income tax. Defenders of public insurance refer to the non-payment of corporate income tax as a matter which is "purely academic"[33] because the government plans operate on a break-even basis. This argument completely misses the point. As the Woods, Gordon Report states, in summarizing the disadvantages of public insurance, "loss of corporate tax revenues may need to be balanced through higher taxes in other areas."[34]

Another argument advanced in favour of public insurance, in my view with distressing frequency, is that public insurers concentrate their investments within the province. This argument is flawed. Public insurers no less than private insurers owe a duty to their policyholders to make the most efficient use of capital. The I.C.B.C. seems to do just that. Over 70% of I.C.B.C.

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[32] Halpern's study notes that private insurers get volume discounts from repair shops, a practice thought inappropriate for a Crown corporation.

[33] See Insurance Corporation of British Columbia, Comparative Aspects.

[34] Woods, Gordon & Co., Government Ownership of Automobile Insurance. A Report...for the Select Committee on Company Law (1978), p. 88.

investments appear to be out-of-province.[35] Moreover, at a time when jurisdictional barriers to capital markets are being lowered, if not eliminated, it seems hard to justify an insurance company policy that would result in increased premiums because of decreased investment returns.

Another argument put forward in favour of public automobile insurance is that it provides more convenient service for consumers. I have no evidence to suggest that the consumers in the public plans are more or less satisfied than consumers in Ontario. I did not make any inquiries as to the level of consumer satisfaction in the public plans. I am prepared to assume their customers are satisfied. Judging by the submission received by this Inquiry and an analysis of the complaints lodged with the Superintendent of Insurance, vehicle damage service complaints seem to be among the least of Ontario consumer concerns.

There is one further matter that deserves brief comment. Defenders of private sector automobile insurance submit that because public plans do not require the equity cushion that regulators in private sector delivery systems demand, public plans are the beneficiaries of an indirect subsidy. I do not think this argument has merit. The "missing" equity cushion in the public plans is used elsewhere.

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[35] I.C.B.C., Annual Statement, 1986, p. 17.

(c) Woods, Gordon & Co. Report

In its 1977 Report, the Select Committee on Company Law indicated it would

> ...seek to determine in detail the elements of public ownership of the automobile insurance business and how they vary from private ownership with a view to making recommendations on this issue.[36]

The Committee commissioned Woods, Gordon & Co. to prepare a report on public automobile insurance. The Woods, Gordon Report, Government Ownership of Automobile Insurance, was delivered in January 1978. As many who argue in favour of a public automobile insurance plan for Ontario rely upon this Report, I thought it important to examine the Report's findings.

In my view, the Woods, Gordon Report provides a comprehensive and reasonably balanced assessment of the issue. The Report stops short of making a recommendation that Ontario implement government automobile insurance.[37] The Report identified a number of advantages and disadvantages attendant upon establishing public automobile insurance.

Many of the matters which I have considered relevant to an assessment of the issue were also considered by Woods, Gordon. I think it fair to say that our conclusions are generally consistent in principle. The Woods, Gordon Report identified the potential for cost

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[36] Select Committee on Company Law, First Report (1977), p. 242.

[37] The Select Committee, as well, did not recommend that Ontario convert to public automobile insurance.

savings on converting to a public plan. It put the matter on the basis that government insurance is capable of returning a higher percentage of its total revenues to claimants in the form of benefits. The Report attributed these cost savings to two factors; first, because of its monopolistic nature, the government insurer need not incur those costs expended by a private insurance company to ensure the maintenance or expansion of its competitive market position. These are the business acquisition costs to which I have already referred; second, Woods, Gordon suggested that the government insurer would experience a lower level of administration and delivery costs as a result of economies of scale and major structural differences between the government and private industry systems. While I have concluded on the basis of the available evidence that there are no significant economies of scale in the writing of automobile insurance, I have taken into account the lower level of administration and delivery costs that would result from the implementation of a public plan.

In recognizing cost differentials between the public plans and private sector insurers, the Woods, Gordon Report and this Report are on common ground. While we may differ slightly as to the reasons for these cost differentials it is clear that we looked at the same areas and were in general agreement as to the capacity for gross cost savings; however, some qualifying observations are required. Since 1978, when Woods, Gordon considered this issue, public plan/private sector cost differentials have

narrowed[38] to the levels referred to earlier in this chapter. It might also be noted that the Woods, Gordon private sector operating expense estimates may have been too high as their Report did not take into account the operating expense experience of four major Ontario insurers.[39]

The Woods, Gordon Report quite fairly recognized the difficulty of coming to a definitive conclusion on the efficiency issue, and I think even more significantly urged that "considerable care should be exercised in the interpretation of [its] conclusions."[40] The Woods, Gordon Report also addressed the serious start-up and implementation problems, and in doing so recognized the potential adverse consequences for some insurance company employees and for other parts of the insurance industry.

I have thus far dealt with issues addressed both by this Report and the Woods, Gordon Report. I have not made reference to the following additional factors listed in the Woods, Gordon Report. These additional factors include:

(a) the trend to inefficiency in management techniques and operations because of the lack of competition under a public plan;

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[38] This is mainly because the private sector has lowered costs.

[39] State Farm, Royal Insurance, Co-Operators and The Pilot.

[40] Woods, Gordon & Co., Government Ownership of Automobile Insurance, p. 76.

(b) the fact that hidden subsidies may be utilized to cloud true costs in a public plan;

(c) the possible illusion of low premium costs in a public plan;

(d) the possibility that the government corporation will become a political vehicle and deviate from sound insurance practices;

(e) the vulnerability of a public plan to labour problems and pressure groups such as body shop operators and tow truck fleet operators; and

(f) the tendency of a monopoly insurer to oversimplify adjusting decisions.

To the extent that any of these additional considerations have validity, they serve to weaken further the case for public automobile insurance in Ontario. I have not, however, resorted to these factors in proceeding to a judgment on the public automobile insurance issue.

(d) The New Democratic Party Submission

The submission from the New Democratic Party, the major participant in the public automobile insurance debate, requires some comment. The NDP support for public automobile insurance is unqualified.[41] Although I received a number of other submissions which supported government insurance, only the NDP submission attempted to

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[41] I intend to refer only to that part of the NDP submission that deals with public automobile insurance.

address the government insurance issue in a comprehensive way.[42]

Most of the arguments advanced by the NDP in support of public automobile insurance have already been canvassed in this chapter. Nevertheless, I intend to make further brief references to some of the major points made by the NDP in its submission. I will start where the NDP started, with the premium comparison issue. As I have already discussed, premium comparisons are meaningless because premiums are driven by loss costs (which will vary between provinces and even between territories within a province) and because there is cross-subsidization in the public plans. For example, on the basis of 1986 figures, the average loss cost per car in British Columbia was $388; for the Toronto territory the average loss cost per car was $560.[43] This is a 44% differential. All other things being equal, this would suggest that Toronto territory premiums might well be expected to be in the area of 44% higher than in British Columbia. I refer specifically to this example because the NDP submission refers to an I.C.B.C. consultants' report which stated that Toronto premiums for "a mature driver with a mid-priced family car" averaged 35% more in Toronto than in Vancouver. Given the loss cost differential, the existence of this premium differential is hardly surprising; in fact, it would be surprising if it did not exist.

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[42] I also received an interesting, broadly-based submission on the public automobile insurance issue from Stephen Panzer, a law student recently graduated from Osgoode Hall Law School.

[43] See Table 15.1.

One does not even have to go outside British Columbia to observe territorial-based premiums differentials. The premium comparisons put forward by the NDP in an appendix to its submission include eight examples which include comparisons between Vancouver and Victoria premium rates. If factors other than territory are held constant, a driver in Vancouver consistently pays 22% more than the same driver with the same car would pay in Victoria.[44] I mention this not because it is wrong but because it is right. Premiums should differ if expected loss costs in one territory (Vancouver) are higher than in another territory (Victoria).[45]

On the issue of relative efficiency, the NDP submission relies on the 1978 Woods, Gordon Report to which I have already referred. Apart from the Woods, Gordon Report, I have already acknowledged the potential for cost savings based on more current data, were automobile insurance in Ontario to be delivered by a public monopoly. All that need be said here is that the potential for cost savings is considerably less than

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[44] As these examples make evident, it is fallacious to suggest (as the NDP submission does) that Ontario premiums will be reduced under public automobile insurance to British Columbia levels, any more than Vancouver premiums will be reduced to Victoria levels.

[45] The NDP examples compare premiums not loss costs (i.e., pure premiums). Since all other factors have been held constant, one must conclude that the premium differentials between Vancouver and Victoria are based on territorial-based differences in loss costs. It is to be noted that data on loss costs (pure premiums) broken down by territory have not been made available by the public insurers. These data for the private sector are found in the Green Book.

referred to in the Woods, Gordon Report which is now 10 years old. Moreover, the crucial question is not the potential for cost savings but the probability of actual cost savings. Because of that, it is necessary to take account of the major qualifications that have been referred to in that part of this chapter dealing with cost efficiency.

I have already commented on arguments relating to investment within the provinces and public automobile insurance rating practices and do not propose to repeat what I said earlier.

One final matter deserves mention. The NDP submission deals at some length with what the submission refers to as the "major injustices of the private system". These "injustices" seem to fall within the areas of claims and underwriting abuses, both of which can be better addressed by reasonable legislation and regulation than by nationalization. Both have been considered in this Report.

G. CONCLUSION

Both in the introduction to this Report and earlier in this chapter I indicated that before Ontario expropriates the private sector automobile insurance industry and replaces it with a public monopoly there ought to be a clear and convincing case for government automobile insurance. The very proffering of that statement raises, I think appropriately, the question of onus. My conclusion on the public automobile insurance issue has not, however, turned on the application of this onus. In my opinion, Ontario taxpayers and drivers would

not benefit from the conversion to public automobile insurance. The modest potential for cost savings particularly in the area of business acquisition costs would be offset in the short run by the substantial start-up costs of a public plan and would be completely eroded in the longer term by the other cost-based considerations earlier referred to, particularly the elimination of the potential for lower premiums derived from competition.

There are no compelling social benefits or other non-economic justifications which support the case for public automobile insurance. In fact, an assessment of factors unrelated to cost efficiency, particularly the elimination of freedom of choice and substantial employment dislocation (looked at from a non-economic standpoint), attendant upon conversion to a public plan, on balance, reinforces the case against public monopoly. As indicated earlier in this Report, I am not unmindful of private sector abuses. In my opinion these problems must be addressed but the appropriate solution is not nationalization. I, therefore, recommend that Ontario not introduce public automobile insurance.

CHAPTER 16

RATE REGULATION

A. INTRODUCTION

The insurance industry in Canada is regulated in a number of ways by the federal and various provincial governments. There are minimum solvency requirements, licensing requirements for insurers wishing to do business in a particular jurisdiction, requirements for the reporting of financial statements and claims experience, and requirements that the terms and conditions of automobile insurance policies be standardized. In addition, the federal and provincial superintendents of insurance exercise supervisory authority over the operations of insurers.

Except in the field of automobile insurance, government control over the insurance industry in this country has stopped short of regulating the rates charged by insurance companies. Rate regulation has become a common feature of the delivery of automobile insurance in most North American jurisdictions. Rate regulation is the regulation or review by government or by a government authorized agency of the premiums charged by insurers.

The historical development of rate regulation in the United States is dealt with by Professor Halpern.[1] In the United States, state governments have always had primary responsibility for regulating the insurance

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[1] Inquiry Research Study II.

industry.[2] During the 1930s, a number of the practices of insurance companies were criticized and questions were raised about the rate-fixing activities of rating bureaus. This resulted in an anti-trust action against the Southeastern Underwriters Association. The United States Supreme Court, on a jurisdictional question, ruled that federal anti-trust legislation applied to the insurance industry.[3] In order to avoid the prospect of federal regulation, the industry lobbied to have primary regulatory control remain with the states. As a result, in 1945 the United States Congress passed the McCarran-Ferguson Act in which it declared that continued state regulation of insurance was in the public interest.[4] The Act specifically exempted from federal anti-trust laws any insurance company whose rates were effectively regulated by state laws. In order to take advantage of the McCarran-Ferguson exemption, almost all of the American states established state regulation of all forms of insurance.

The Canadian experience has been somewhat different. There has been no catalyst for government regulation of insurance premiums in Canada similar to that provided by the McCarran-Ferguson Act in the United States. One of

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[2] In Canada, a federal presence has always been recognized in the regulation of insurance. See Citizens Insurance Co. v. Parsons (1881), 7 App. Cas. 96.

[3] U.S. v. Southeastern Underwriters Association (1944), 322 U.S. 533.

[4] Pub.L. No. 15, 79th Cong., 1st Sess., 59 Stat. 33, March 9, 1945, 15 U.S.C. Secs. 1011-1014 (1982). The statute provides that federal anti-trust legislation would "be applicable to the business of insurance to the extent that such business is not regulated by State law."

the results of this has been the rather slow development of automobile insurance premium regulation here and the virtual absence of premium regulation in non-automobile lines of insurance.

Regulation of automobile insurance rates did not come to Canada until the 1960s.[5] Nova Scotia, Alberta, New Brunswick and Newfoundland all have some form of rate regulation. Until November 4, 1987, Ontario and Prince Edward Island were the only provinces with virtually no government regulation of automobile insurance premiums. On November 4, 1987 the Ontario government gave first reading to Bill 2, "An Act to establish the Ontario Automobile Insurance Board and to provide for the Review of Automobile Insurance Rates."[6] I will discuss this legislation in more detail later in this chapter. Before doing so, I will outline the different kinds of rate regulation that have been employed in other jurisdictions.

B. TYPES OF RATE REGULATION

There are three basic models now used in the United States and Canada for the regulation of automobile insurance premiums. They are: (a) market competition; (b) file and use; and (c) prior approval. These are all models of rate review. There are other models but these three are the most common. None contemplates the actual

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[5] In discussing rate regulation, I am dealing only with regulation in those provinces where automobile insurance is delivered by the private sector.

[6] The Ontario Automobile Insurance Board Act, 1987.

setting of rates. This distinction is important in terms of the proposed Ontario legislation.

(a) "Market Competition" Regulation

Under this type of regulation there is no formal approval of premiums. The regulatory agency monitors rates in order to identify those markets where market competition is not producing rates roughly approximating those which would occur in a perfectly competitive industry. In such cases, the agency may intervene. Otherwise, the market is left alone. There is generally no requirement for insurers to file their rates or data on loss experience.

The rationale for this regulatory model is that competition is the optimal regulator of prices, and that regulatory intervention is justified only where there is an absence of competition. California, Missouri and Idaho all have market competition regulation; Illinois has now totally deregulated automobile insurance and does not intervene in any form.

(b) File and Use Regulation

Under this regulatory model an insurer may put proposed rate changes into effect either immediately upon filing with the regulatory agency or after a relatively short waiting period. The insurer's filing typically includes proposed rates, evidence on losses, expenses and underwriting profits or losses. Hearings may be held if the regulatory body questions or disapproves of the insurer's rate submission, although in practice rate disputes are often resolved by compromise. Nova Scotia

has had a file and use system for automobile insurance rates since 1960.

(c) Prior Approval Regulation

This model requires the filing and regulatory approval of proposed rates before they are used. In all prior approval jurisdictions, there is provision for a hearing to consider the insurer's rate submission. The scope of the hearing and the identification of those who are entitled to participate in it vary from jurisdiction to jurisdiction.

Among Canadian provinces, Alberta, New Brunswick and Newfoundland all have prior approval systems of rate regulation for automobile insurance. Alberta brought in its rate review legislation in 1970. It is administered by the Alberta Automobile Insurance Board, an independent agency created by statute. At present, the Board has four members. Its chairman is Mr. Justice Wachowich, an Alberta Court of Queen's Bench trial judge. The other members are an accountant, a broker and a representative of the public. The Board, where necessary, hires an independent actuary on a consulting basis to study the various rate proposals. The Alberta Board has jurisdiction only over the compulsory section of the policy as compared to, for example, the New Brunswick and Newfoundland boards which have jurisdiction over the whole policy. Public hearings are rare. Most rate proposals are dealt with on the basis of written submissions.[7] The

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[7]The Board has the same powers as a commissioner under the Alberta Public Inquiries Act.

Alberta Board takes a relatively informal approach to its deliberations, in part borne of the belief that competition is the best method to improve the price to the public.[8] It has been suggested that the Alberta Board has never failed to approve a proposed rate. Even if correct, this suggestion overlooks the fact that the very existence of a rate review board is likely to have a modifying effect on insurer behaviour, as well as the fact that in any given case the Board may privately have insisted an insurer make changes to its rates before approval would be granted. From the discussions I have had, it would appear that the Alberta rate review process is functioning well. As much as anything else, this may be a testimony to the personnel of the Board.

C. ONTARIO

Regulation of automobile insurance rates in Ontario has, up until now, been virtually non-existent. Section 369 of the Insurance Act prohibits the fixing of rates that unfairly discriminate between risks, but the section has never been proclaimed in force.[9] Section 371 of the Act gives the Superintendent the authority to order

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[8] The legislation also provides that if an insurer files proposed rates and the Board does not deal with the submission for 60 days, then the rates are automatically approved. This has never in fact happened.

[9] R.S.O. 1980, c. 218, as amended. Section 369(2) provides that the section does not come into force until proclaimed. Section 394 provides that no person shall engage in any unfair or deceptive act or practice in the business of insurance, but it has not been used in respect of alleged unfair rates. See Re Bates and Zurich Ins. Co., [1985] I.L.R. 1-1942; reversed [1987] I.L.R. 1-2148 (Ont. Div. Ct.).

an adjustment of the rates for automobile insurance whenever he finds that any such rates are "excessive, inadequate, unfairly discriminatory or otherwise unreasonable",[10] but this section too has never been proclaimed in force. In the regular market, the only obligations on an insurer or a rating bureau (in practice, the Insurers Advisory Association (the I.A.O.)) are reporting requirements. Section 80 requires the filing of the statistical experience of insurers with the Superintendent. Under section 366 of the Act, a rating bureau and a licensed insurer are obligated to make a return under oath to the Superintendent showing every schedule of rates charged by them and any change of rates.[11]

The only formal rate regulation in Ontario occurs in the residual market. Facility Association rates are subject to the prior approval of the Superintendent. The Superintendent has 60 days within which to approve, disallow or vary the filing.[12]

The Superintendent exerts powers of moral suasion to control the activities of Ontario's automobile and other insurers. The fact remains that Ontario to date has operated on the premise that "he who regulates best, regulates least".

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[10] Subsection 371(1).

[11] It is an offence to deviate from rates that have been filed (section 366(4)).

[12] Compulsory Automobile Insurance Act, R.S.O. 1980, c. 83, s. 10.

That premise changed in the spring of 1987. Against the background of increasing premiums, complaints about abusive underwriting practices and the call for publicly delivered automobile insurance, the provincial government, on April 23, 1987, announced its intention to regulate automobile insurance rates. In a political response to a perceived or real political problem, automobile insurance premiums were frozen at April 23, 1987 levels, and premium roll backs in the range of 10% were prescribed for males under 25 years of age and for taxis. Draft legislation, "An Act to control temporarily Automobile Insurance Rates in Ontario" was prepared but never enacted because the industry agreed "voluntarily" to abide by its terms. Draft rate regulation was also prepared and circulated for comment. As I have indicated, the draft bill is now before the Legislature and it seems inevitable that Ontario will soon have some form of rate regulation.

D. THE ONTARIO AUTOMOBILE INSURANCE BOARD ACT, 1987

The proposed legislation, if enacted in its present form, will take Ontario from one of the least regulated to one of the most regulated jurisdictions for automobile insurance in North America. The regulatory control contemplated by the statute is not just rate review, but rate setting as well. The legislation combines elements of prior approval and file and use systems, but superimposes the initial establishment of rates by the regulatory agency itself.

The statute is to be administered by the Ontario Automobile Insurance Board whose members are to be appointed by the provincial Cabinet. The Board is given

extensive powers with respect to practice, procedure, inspections and production of documents. The Board's orders are protected by a privative clause, but there is provision for an appeal, with leave to the Divisional Court of the Supreme Court of Ontario, only on a question of law or jurisdiction.

The legislation establishes a three-tiered procedure for setting rates on an industry-wide basis and for approving rates of individual insurers:

(1) rates are set within a classification system prescribed by Cabinet and set out in regulations under the Act. Insurers are obliged to use the prescribed classification system unless otherwise permitted under the Act;

(2) industry-wide hearings are held by the Board for the purpose of determining a rate or range of rates for each class within the prescribed classification system. Industry-wide hearings may also be held when rates or ranges of rates are reviewed. Notice of the industry-wide hearings must be given to the public. Every insurer is entitled to be a party at the hearing and the Board may name other parties. The rate or range of rates takes effect 120 days after the Board's order is made;

(3) each insurer must then apply to have its rates approved by the Board. In cases where an insurer's proposed rates or variations of previously approved rates fall within the range of rates set by the Board, its application is

deemed to be approved[13] 20 days after filing unless the Board advises otherwise.[14] In cases where an insurer wishes to charge a rate outside the range set by the Board, it requires prior and specific Board approval, and it must demonstrate "that the proposed rate is just and reasonable and not excessive or inadequate and that the circumstances of the insurer justify the use of the proposed rate." The legislation does not prescribe any time period within which the Board must approve, reject or vary a proposed deviated rate. While the Board's decision is pending, the insurer may charge the same rate or a lower rate than it was charging when the application was made. Accordingly, it is only proposed rate increases above rates set by the Board that cannot be implemented without prior approval. Nonetheless, insurers who want to use rates below the rates (or range of rates) set by the Board must apply for approval

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[13] Where an insurer applies to use a rate which is the same as the rate set by the Board or within the range of rates set by the Board, the insurer only has to file a statutory declaration that it is using the rates set by the Board.

[14] The Ontario bill is similar in some respects to the "flex-rating" system of regulation adopted by New York State in 1986 for its commercial (but not automobile) lines of insurance. Flex-rating permits rate changes within a fairly narrow range on a "file and use" basis. Changes outside the range are available only on a prior approval basis. The theory is to allow some measure of competition, but to avoid sudden large premium increases.

> presumably against the criterion of "inadequacy".[15]

Facility Association rates also require specific Board approval, but are not part of the industry-wide rate setting procedure. Insurers are prohibited under the Act from charging any rates not approved by the Board. There are transitional provisions that govern until the Board sets rates and that deal with the capping of rates on April 23, 1987. Fines of up to $100,000 are prescribed for a breach of the legislation.

E. THE CASE FOR RATE REGULATION

The threshold question is whether any form of regulation of automobile insurance premiums is appropriate. While I think the question deserves to be answered, it is clearly inevitable from a political standpoint that automobile insurance premiums in Ontario are going to be regulated. Quite apart from political realities, I regard some form of rate regulation as desirable. My endorsement of regulatory supervision of automobile insurance premiums does not include an endorsement of the concept of premium setting.

Although economists may be correct that in a competitive industry insurers will inevitably charge reasonable premiums, some outside review of insurers' premiums is socially, if not economically desirable. The consuming public, which in general has little knowledge about automobile insurance, I think, expects it. The

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[15] See subsection 23(3).

public is required to buy automobile insurance and is entitled to some external protection against unreasonable or unjust premiums. Furthermore, the very existence of a rate review body will likely exert a modifying influence on insurer behaviour. From the insurers' perspective, rate regulation should also bring a measure of stability to the market.

Historically, instability has been manifested not only by questionable premium increases, but also by premium decreases. Rate regulation should control both inappropriate rate increases and decreases. When an insurer increases premiums other insurers may well decide not to follow. The situation is different when an insurer lowers premiums. When that occurs, other insurers have two choices: they can either follow that lead and drop prices, or maintain present price levels and lose business to the competition. When profit margins are high, the answer is clear and presents no problem: drop prices. The answer is not so clear when the insurer is operating at a break-even point, or losing money.

Two factors motivate an insurer to drop prices even though it may seem at first blush to be inappropriate to do so. Both relate to the cost of re-establishing market share. First, it is significantly more costly to write new business than to renew existing business. Second, historically, loss ratios of newly written business are significantly higher than the loss ratios for existing business. This seems to be a product of the benefits of renewing known risks as opposed to the uncertainties of

writing unknown risks.[16] The result is once even a reasonably-sized insurer reduces premiums, there is an incentive for others to follow. Inevitably, upward corrections have to be made and they can be painful for the consumer: witness the premium increases in 1985-86.

I conclude that from a social policy viewpoint, if not from a purely theoretical economic viewpoint, some form of rate regulation for the automobile insurance industry in Ontario is desirable. Accepting that as a given, the real question turns on the extent of that regulation.

The basic thesis of Professor Halpern's study is that the degree of government intervention should be proportional to the extent to which the market deviates from the competitive norm or, in other words, the extent to which the competitive market does not reach its full potential. To use an overly intrusive regulatory response when less intrusive measures will adequately address the perceived problems is likely to be very costly to the economy and to the consumer.

Although in my opinion there are other issues which merit consideration it is at least necessary to examine

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[16] One major insurer informed me that policies that are in their first annual term (new business) have an average loss ratio that historically runs between 20-25% higher than old business. In this regard there may well be a difference between an insured who changes brokers and insurers, and an insured who continues to do business with the same broker but changes insurers. In the latter case, the insured is at least known to the broker.

the state of competition in the Ontario automobile insurance industry.

F. COMPETITIVENESS IN THE ONTARIO AUTOMOBILE INSURANCE INDUSTRY

Professor Halpern and his colleagues examined this issue by considering the structure of the industry and the conduct and performance of the companies within the industry. Market structure includes, among other things, the number of firms, their size distribution, the ease of entry and exit and the potential for collusive activities.

The number of firms in the Ontario automobile insurance market is large by any standards. In 1984, there were 157 companies writing automobile insurance premiums. Some of these companies were under common ownership. When this factor was taken into account there were 112 groups[17] writing automobile insurance policies in the province.

While the absolute number of firms gives some indication of the competitive nature of the industry, it does not take into account the relative size distribution of the companies. Relative size is significant in the sense that the potential for collusion or monopolistic control is more likely in an industry where say five firms account for 90% of industry sales than when those

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[17] The figure comes from Professor Potvin's paper. See Inquiry Research Study II. A "group" refers to one or more insurance companies under common ownership. Of the 112 groups, 63 accounted for 99.09% of direct premiums written.

firms account for only 20%. To assess the degree of industry concentration, economists have developed two indices of measurement. One is the concentration ratio; it measures (in the automobile insurance context) the proportion of direct premiums written by a given number of firms. The second is the Herfindahl index; it is the sum of the squares of each firm's market share divided by the number of firms. In a pure monopoly, the value of the Herfindahl index is 1.0. The greater the inequality of market shares, the closer the value of the index will be to one.[18] Conversely, as the number of firms becomes larger, the Herfindahl index approaches zero.

In 1984, the largest company, Co-Operators Insurance, had 9.39% of the Ontario market; Zurich Insurance which ranked 8th had 3.64% of the market; and Gore Mutual which ranked 20th had 1.60% of the market. Looking at concentration ratios for 1984, the top four firms accounted for 27.8% of direct premiums written, the top 8 firms 44.53% and the top 20 firms 73.95%.

The Herfindahl index had a value of .0370 in 1984. This is equivalent to 27 entities of equal size. Professor Potvin's study indicates that industry concentration, which had increased between 1974 and 1979, has been falling since 1979 with the result that 1974 and 1984 values are approximately the same. Furthermore, a comparison with 20 selected Canadian industries indicates that over one-half of those industries are less competitive than Ontario's automobile insurance

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[18]This is because the index is based upon the squared value of each firm's market share.

industry.[19] The conclusion which emerges from this analysis is that the structure of the automobile insurance market is consistent with a highly competitive industry. Moreover, as Professor Halpern observes, this analysis likely underestimates the degree of competition since it does not take account of potential competition. Moreover, the large number of firms in the industry and their relative size distributions make collusion unlikely.

In addition to industry concentration, the existence or absence of barriers to entry into and exit from the industry are a reliable indication of market competitiveness. On this subject, Professor Halpern's study comes to three important conclusions. First, external barriers to entry, in terms of government regulatory requirements,[20] sunk costs,[21] the establishment of a brokerage or agency system and the reinsurance

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[19] Potvin uses national concentration measures for the 20 selected industries, but Ontario concentration measures only for automobile insurance. Since a given industry will usually appear more concentrated, the smaller the geographical area the comparison is somewhat biased in making the automobile insurance industry appear more concentrated than if national figures for the automobile insurance industry were used. Even so, it remains by comparison quite competitive.

[20] Halpern concludes that minimum capital and surplus requirements of at least $1 million and the premium/equity capital ratio requirements do not inhibit entry.

[21] Sunk costs refer to the investments made by existing companies such as costs relating to the establishment of a distribution system and the establishment of a company regulation. Halpern concludes that the effect of this factor on barriers to entry is small.

market,[22] are minor and should not affect ease of entry or exit. Second, internal barriers to entry are also minimal; there do not appear to be any economies of scale[23] in automobile insurance and only minor economies associated with delivering more than one line of insurance.[24] Third, the empirical evidence on entry and exit is consistent with the absence of barriers to entry. Between 1975 and 1984, 67 groups entered the Ontario market and 87 left. In short, the cost structure in the industry and its impact on entry and exit is consistent with a competitive market.

Halpern also considered whether the existence of the I.A.O., a rating bureau which publishes recommended automobile insurance rates based on target expense and loss ratios, could facilitate monopolistic pricing. Given that not all companies are members of the I.A.O., that there is no obligation even on members to abide by the recommended rates and that there is no mechanism within the I.A.O. to enforce cartel-like behaviour, the conclusion that the I.A.O. does not facilitate collusion among insurers seems reasonable.

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[22] A monopolistic reinsurance market might inhibit entry. Halpern finds, however, that the automobile reinsurance market, while more concentrated than the automobile insurance market, is still consistent with a competitive industry.

[23] Economies of scale refer to decreasing average costs as the output of a particular product increases.

[24] Halpern refers to the interactions among products (or different lines of insurance) as economies of scope. In the insurance context, economies of scope will exist if the marginal cost of writing more automobile insurance depends upon the existence of other lines of insurance.

Finally, Halpern evaluated the performance of the Ontario automobile insurance industry to determine whether it was consistent with competitive or monopolistic behaviour. The evidence that bears on this question is referred to in Halpern's Inquiry Research Study[25] and has been discussed in Chapter 15. Halpern concluded that the performance of the industry is essentially competitive.

The conclusion that the automobile insurance industry in Ontario is competitive must be qualified in three important respects. First, while there are a large number of companies selling automobile insurance in the province, in practice, consumer choices are, in many instances, much more limited. Automobile insurance is sold through brokers and captive agents.[26] Few brokers represent more than five or six insurers; many represent less. Consumers by and large are unaware of this. Captive agents represent one insurer. Through lack of knowledge, or for other reasons, many consumers do not shop around among brokers and agents.[27] In a real sense, the broker and agent distribution system fragments the competitive market. The problem is accentuated in rural areas where there is often only one agent or broker. Even if a prospective buyer of automobile insurance were inclined to seek out the best prices, his choices are in practical terms often restricted.

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[25] Inquiry Research Study II.

[26] Captive agents are sales agents for direct writers.

[27] Obviously, some consumers do shop around. Halpern estimates that the lapse rate with the insured's current broker is about 15 to 30% per year.

Second, in some particular markets competition is in fact quite limited. Taxicabs are one example; only two or three companies write this business. One result is that many taxicab owners find themselves insured through the Facility Association. Other examples of particular markets where the choice is limited include motorcycles, inter-urban trucks, funeral hearses, ambulances, and high risk private passenger vehicle operators. The conclusion about the competitiveness of the industry as a whole does not apply to these particular sub-markets.

Third, an examination of those insured in the Facility Association confirms the absence of competition for the business referred to above. The Facility Association pooling arrangement, participated in by all insurers, is by definition non-competitive.

G. ASSESSMENT OF THE PROPOSED ONTARIO RATE REGULATION LEGISLATION

Before making some general comments about the draft Ontario legislation, I propose to set out what I think the objectives of legislation of this kind ought to be. This is a separate issue from whether there should be any form of rate regulation in the first place. That issue was discussed earlier in this chapter.

Given a reasonable classification system and leaving aside individual underwriting abuses, in my opinion the two dominant objectives of rate regulation should be premium fairness as assessed against sound insurance principles and market stability which will enure to the eventual benefit of the public. Appropriate rate

regulation should provide a cost efficient mechanism for ensuring that premiums charged by individual insurers are fair and for ensuring market stability.

It seems clear to me that to the extent the insurance industry supports the proposed form of rate setting and rate regulation, that support is premised on the insurers' perception of a need for market stability, not on the view that regulation is required to ensure fair premiums. If forced to make a choice, in my opinion the objective of premium fairness is far more important than that of achieving market stability. Premium fairness will not be achieved if the regulatory scheme is unnecessarily costly or if it works to inhibit competition among insurers. The proposed Ontario legislation is suspect on both counts.

The legislation contemplates a very rigid classification system prescribed by regulation and not under the control of the Board. This combination will inhibit insurers from being innovative in their rating procedures. The ability to innovate and to refine the classification system is beneficial to consumers; legislation which restricts that ability is not. It is not entirely clear to me whether the Board will have the power to approve deviated rates where refinements to the classification system may be involved but where the rates are otherwise just, reasonable and sound in principle. In some way the Board should clearly have this power. Some have suggested that the Board be given jurisdiction over the classification system and, I assume, the authority to

permit insurers to introduce refinements to the system.[28] This may work. Giving the Board authority over the classification system will likely have the advantage of depoliticizing the establishment of appropriate rating criteria. If this approach is taken the Board must have the power to modify the classification system. However it is done, insurers should not only have the right to innovate within reasonable perimeters, they should be encouraged to do so. I do not envisage the approval of deviated rates on the basis of socially unacceptable rating criteria, however actuarially sound these criteria may be. For example, if sex is held to be unacceptable on constitutional or other grounds it should not be used under any circumstances.

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[28]The I.A.O. makes this point in a letter dated August 23, 1987 to the Minister of Financial Institutions. The I.A.O. has also expressed concern about subsection 11(6) of the draft legislation which provides:

> Where two or more parties have a common interest in respect of an application to the Board, the parties may authorize one or more of those parties to represent all of them and any order made by the Board may be made applicable to all.

The concern is that the I.A.O. might be asked to make submissions on behalf of some of its members and yet the subsequent ruling may bind all members. In the I.A.O.'s view, this provision may jeopardize its ability to provide actuarial assistance to smaller insurers who do not have their own "in house" actuaries. The I.A.O. wishes to be able to make submission on its own without precluding member companies from making their own individual submissions. If the I.A.O. submission is agreed to by member companies, the I.A.O. suggests that the member companies need simply indicate as much. I am in agreement with the I.A.O.'s position, on subsection 11(6).

The most significant feature of the Ontario bill is the provision for the setting of rates following an industry-wide hearing. It is this feature which distinguishes Ontario's proposed statute from rate regulation in other provinces, or for that matter from the file and use or prior approval systems used to review automobile insurance rates in the United States.

The Ontario bill, at the industry-wide hearing level, parallels the regulatory model for public utilities. This regulatory model is essentially "cost plus" regulation. The basic rationale for this kind of regulation is that the utility is a monopoly and thus there is no competition to generate acceptable prices or to provide restrictions on excess profits. It seems to me that the public utility model of regulation is inappropriate to a competitive industry even if the product is compulsory. Given a competitive industry, public utility type regulation will in the long run encourage inefficiency at least in the sense it does not provide positive incentives for efficiency.

What is going to be accomplished by these industry-wide hearings? What will emerge is a series of rates (or ranges of rates) for the various prescribed classes of risk which will inevitably compress rate differentials that now exist among insurers. If the rates or ranges of rates were consistent with those generated by competitive pricing, I would be less troubled by the legislation. That, sadly, will not happen as I see it. Because benchmark rates will take account of the experience of all insurers, efficient and inefficient, the benchmark rates will congregate around the average industry experience. Hence the public will be denied the benefits of true

competition, and on a more specific level, will be denied the benefit of lower than benchmark rates which would be charged by the more efficient insurers in a truly competitive market. While efficient insurers could seek approval for lower than benchmark rates, they may not have to do so in order to maintain or even increase their market share. I concede that industry-wide hearings may achieve a measure of stability. Consumers would prefer lower premiums.

There is also the matter of cost. Any form of rate regulation will involve some costs. I do not think it is unreasonable to measure these costs against the benefits of the proposed regulatory scheme. There are two dimensions to the cost component of the scheme envisaged by the proposed Ontario legislation. There are the internal costs of the Board and there are the external costs related to the entire regulatory process, including particularly industry-wide hearings. The requirement for industry-wide hearings means that there will have to be a sizeable bureaucracy established to administer the scheme. The proposed legislation provides that the expenses and expenditures of the Board are to be paid by individual insurers on a pro rata basis and thus indirectly by Ontario motorists.[29]

The industry-wide hearings themselves are going to be lengthy, cumbersome and expensive. Actuaries will be required; undoubtedly so will lawyers. The costs of these

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[29]See section 10. I note that this approach is not taken in Alberta where the costs are paid out of general revenues. I endorse the Ontario approach.

hearings are going to be inordinately high. These costs, too, will be passed on and paid for by Ontario motorists.

I recognize that industry-wide hearings will in many instances make the rate approval process for individual insurers almost a formality, provided approval is not sought for deviated rates above the rate or range of rates established by the Board. Additional costs incurred at the industry-wide hearing level will be partially offset by reduced costs at the level of the approval of individual rate applications. An insurer wishing to charge a deviated rate (above the rate or range set by the Board) will be exposed both to the expense of the industry-wide hearings and its own rate application which requires prior approval by the Board.

If these additional costs were justified by a process which resulted in lower premiums, I would not be so critical of this legislation. While the process will lead to premium stability, it will not lead to lower premiums. The form of the process will result in increased costs which will inevitably be passed on to consumers. The substance of the process will deny consumers access to the lower premiums generated by the more efficient insurers in a competitive market.

To my initial surprise, during the course of this Inquiry it became apparent to me that a significant number of insurers supported the proposed form of rate setting and rate regulation. That support alone might cause one to pause. It is now clear to me that the insurers supporting this legislation view it as a vehicle through which real price competition can be avoided, and

profit stability can be virtually guaranteed through the rate setting process.

There is one further matter concerning industry-wide hearings that deserves comment. The legislation encourages consumer participation at these hearings. If the industry-wide hearings process is to remain part of the legislation, I think public participation is to be encouraged. The effectiveness of that participation, however, is a crucial consideration. Without the provision of funding, I cannot see how public participation can be meaningful. Those representing the public must have access to actuarial and other experts and to industry data. Otherwise, public participation is unlikely to be of much assistance to the Board.

The industry-wide hearing process for the setting of rates must be distinguished from the process contemplated for approving the rates of individual insurers. The draft bill contemplates a form of file and use if the insurer's rates are within the range established by the Board; and a form of prior approval for deviated rates. In my view, the distinction between prior approval and file and use is less important than the manner in which the regulatory agency actually supervises individual insurers in the process of approving their premium rates. Prior approval has worked well in Alberta; file and use systems have been successfully resorted to in many jurisdictions in North America. I tend to disagree with Halpern's strong preference for file and use, but I do subscribe to the view that the rate approval process should not unduly inhibit competition. A rate board's fundamental mandate is to ensure that consumers obtain the benefit of reasonable, just premium rates. That will only happen if

insurers are allowed, or some would suggest forced, to compete.

The regulation of Facility Association premiums requires a brief comment. In the proposed legislation, Facility Association premiums are subject to Board approval. Under the Compulsory Automobile Insurance Act,[30] Facility Association rates require approval by the Superintendent of Insurance. I do not regard the source of approval to be of much importance. What is more important are the criteria to be resorted to in the setting of Facility Association premiums. The proposed legislation requires the Facility Association to "demonstrate that the proposed rates are just and reasonable and not excessive or inadequate". Under the current legislation, the onus is reversed and the statutory criteria are more specific. The Superintendent can only disallow or vary a Facility Association rate filing where in his opinion "the rates are not in accordance with statistical evidence or experience or other justifiable factor".

Whatever statutory criteria are used, it is inescapable that the approval of Facility Association rates will involve substantial social policy considerations.

I think it must be recognized at the outset that Facility Association premiums are not now, and in practice will not be, self-sustaining. In other words, premiums in the Facility Association are lower than the expected loss

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[30]R.S.O. 1980, c. 83, s. 10.

costs of those who populate the Facility Association suggest they should be. This inevitably means that there is a measure of cross-subsidization arising out of the rate structure. Drivers in the regular market are paying higher premiums than they otherwise would in order to subsidize drivers in the Facility Association. The extent of cross-subsidization in the residual market in Ontario has been relatively modest. I think it is significant and wrong that there has been no real acknowledgement that there are social policy considerations relating to the setting of Facility Association premiums, and no discussion of what social policy considerations should dominate.

Some seductively simple solutions have been proposed to resolve what many view as a central dilemma, namely the significant differential between regular market premiums and Facility Association premiums. The focus of this concern is on clean drivers who for whatever reason find themselves insured in the residual market. This problem was discussed in Chapter 7, as was the I.B.C.'s proposed solution.

I have the following recommendations which are the product of my view that it is critical to come to grips with issues bearing upon the residual market including residual market premiums immediately.

1. Clean risks in the residual market are the main problem. I recognize that the loss ratio of that group is bad. Nevertheless, it seems hard to justify the high premiums charged to those good clean risks in the residual market. Moreover, I am fearful that with the advent of the new classification system and

the proposed form of rate regulation, the population of the Facility Association may expand. I, therefore, recommend that for clean risks we return to the old Facility ceding arrangements. How much of a clean risk could be ceded should be discussed by the insurance industry, the Facility Association and the Superintendent of Insurance. I do not regard the issue of whether ceding will be at 85% as was the case in the Facility, or at some different level, to be a matter of great immediate consequence. The ceding should occur at the insurer's book premium unless the insurer's premium is below the range of rates set by the Board. For the purpose of this recommendation, I am assuming that the Board will retain a rate setting function.

2. For demonstrably bad risks, the Facility Association pooling mechanism should continue to be used. The draft legislation requires the Board in approving Facility Association premiums to use the same criteria as used for approval of regular market rates of individual insurers. Inevitably, Facility Association premiums will be premised as much on social policy considerations as on actuarial evidence. The Board will have to determine the extent to which cross-subsidization is justified in the Facility Association rate approval process. In practice, the Facility Association will present evidence of its expected loss costs and other relevant statistical data, much as an insurer would. The Board will then be called upon both to respond to the evidence presented, and apply to social policy considerations implicit in the approval of premiums that demonstrably will not meet expected loss costs.

I do not think it is desirable that the consideration of these social policy issues be left solely to the insurance industry (through its Facility Association representation) and the Board. There must be a voice to represent the public interest. This can best be accomplished through the office of the Superintendent of Insurance. I, therefore, recommend that the Superintendent of Insurance be permitted to participate in the Facility Association premium approval process. Whether this involves a formal rate filing can best be left to the Board.

CHAPTER 17

MOTOR VEHICLE ACCIDENT PREVENTION

Although not strictly within my terms of reference, I did not wish to end this Report without making some reference to accident prevention. The discussion about loss costs and premiums should not obscure the fact that the best available cost control device is effective accident prevention. If the frequency and severity of accidents can be reduced, not only will premiums fall, but more importantly, lives will be saved and the tragedy of disability will be lessened.

A. THE SOCIAL AND ECONOMIC COSTS OF MOTOR VEHICLE ACCIDENTS IN ONTARIO

The social and economic cost of motor vehicle accidents is staggering. In 1986, approximately 6% of Ontario drivers were involved in 187,286 reported motor vehicle accidents; over 100,000 were injured; 1,102 were killed.[1] The average Ontario driver, if licensed at age 16, will drive 650,000 kilometres, become involved in two motor vehicle accidents and be injured in one of them. One in 100 will be killed.[2]

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[1] Ontario Road Safety Annual Report, 1986.

[2] The average distance driven in 1986 was 11,768 kilometres. Assuming that a driver gets his licence at age 16 and drives for 55 years, he will drive 647,240 kilometres over a lifetime. The accident rate is 274 per 100 million kilometres driven. The injury rate is 1.6 per million kilometres driven, which translates into 1.03 injuries in 647,240 kilometres driven. The death rate is 1.6 deaths per 100 million kilometres driven, or .010 deaths in 647,240 kilometres, which translates into a 1 in 100 chance of being killed. (Ontario Road Safety Annual Report, 1985).

The tragedy of motor vehicle accident fatalities is accentuated by an assessment of those who are killed. As in war, those killed in motor vehicle accidents tend to be young, healthy and male. Motor vehicle accidents are the leading cause of death for males between ages 15 and 24. Forty percent of males who die between ages 15 and 24 die as a result of motor vehicle accident injuries.[3]

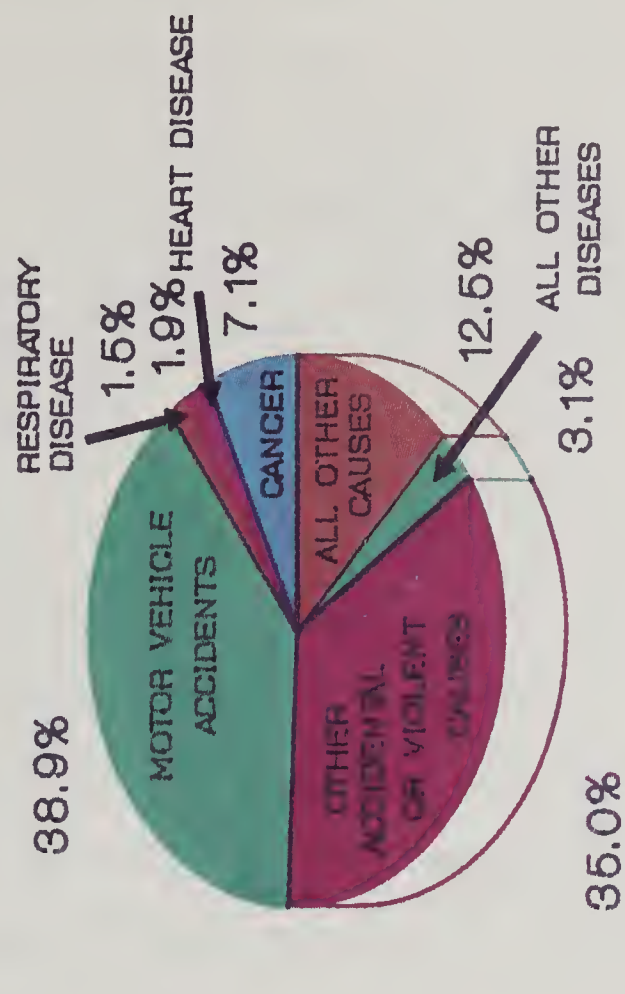
When women are considered, the death rate percentage figures do not change significantly, although there are many more young men than young women who die as a result of car accidents. Figure 17.1 shows the major causes of death in Canada in 1985 for all age groups and for the age group 15 to 24. Automobile accidents account for 2.3% of deaths in all age groups but 38.9% of deaths in the 15 to 24 age group.

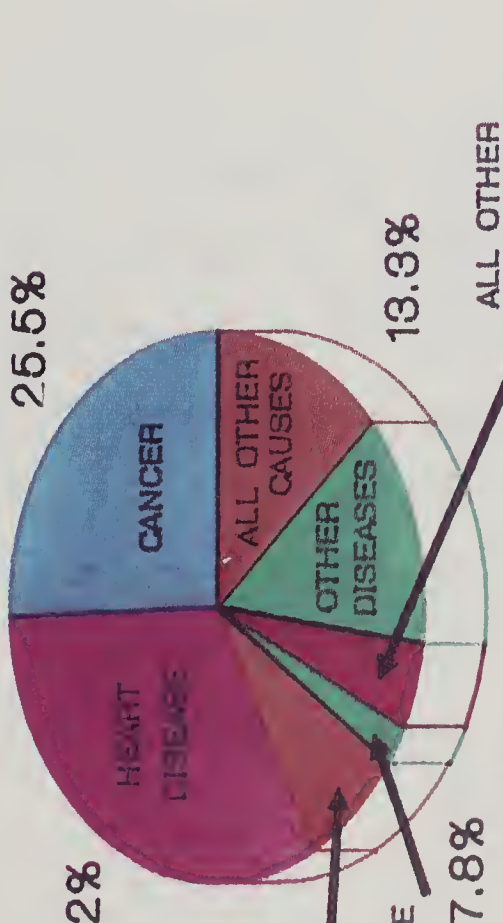
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[3]Statistics Canada: The death rate per 100,000 in that group is 47.6 for males 15-24. Suicide is next at 24.6 deaths per 100,000 population. All other accidents claim 18.25 lives per 100,000 population. The total death rate is 119.8 per 100,000 males between 15-24. 47.6 as a percentage of 119.8 equals 39.7%.

Figure 17.1

MAJOR CAUSES OF DEATH
CANADA: 1985





SOURCE: STATISTICS CANADA

The human suffering and the social dislocation caused by motor vehicle accidents cannot be economically measured, but there have been attempts to estimate the pure economic costs of motor vehicle accidents. Two such studies require brief comment. Both are discussed in more detail in Appendix IX.

In 1982, the U.S. Department of Transportation attempted to calculate the economic cost of motor vehicle accidents in the United States. The data then collected were updated in 1985. This study concluded that the economic cost of motor vehicle accidents in the United States was approximately $23.5 billion, expressed in 1984 dollars.

A 1982 Ontario study estimated the economic cost of motor vehicle accidents in Ontario to be about $1 billion dollars. This is consistent with the findings of the American study referred to above when population differences are taken into account. If adjustments are made for some of the questionable assumptions of the Ontario study[4] and the figures are expressed in 1985 dollars, the Ontario loss figure is approximately $1.7 billion.

In 1985 dollars, economic loss resulting from Ontario motor vehicle accidents is approximately $187 for every man, woman and child in the province or $292 for every

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[4] See Appendix IX.

licensed driver in Ontario.[5] These figures do not take pain and suffering resulting from motor vehicle accidents into account.

B. ACCIDENTS: TRENDS AND RATES

Depressing as motor vehicle accident statistics may seem to be, the news is not all bad. The risk of driving has improved over the past 50 years. The number of fatal accidents has declined; the number and rate of bodily injury and property damage accidents has remained relatively stable in the last 10 years. There has been a significant decline in the fatal accident rate in the past 20 years; in the last 5 years the fatal accident rate has remained stable.

(a) Trends

Figure 17.2 sets out the number of property damage, bodily injury and fatal accidents in Ontario between 1965 and 1986. The red fatal accident line on Figure 17.1 is almost invisible because the number of fatal accidents is small compared to the number of property damage and bodily injury accidents. Fatal accident trends are therefore set out separately on Figure 17.3. Figure 17.2 shows that the number of bodily injury accidents has remained relatively stable. The property damage line is less stable. The number of property damage-only accidents hit its peak in 1977. From 1978 to 1986 Figure 17.2 shows a relatively stable property damage accident line.

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[5] Ontario population reported in the Ontario Road Safety Annual Report, 1985 was 9,066,000. Dividing this into a cost of motor vehicle accidents of $1,697,921,213 results in a per person cost of $187.28.

Figure 17.2

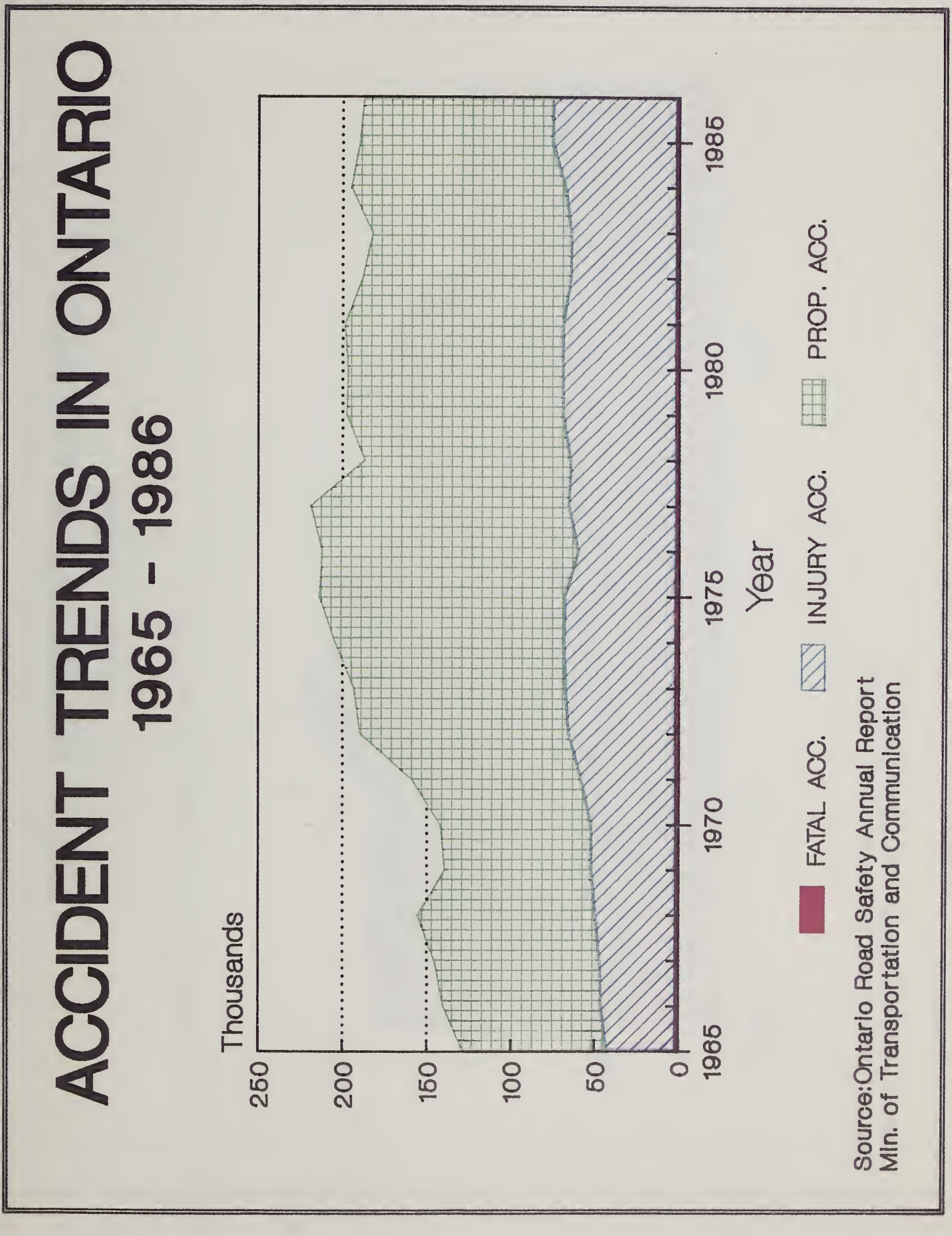

ACCIDENT TRENDS IN ONTARIO
1965 - 1986
Thousands
250
200
150
100
50
0
1965
1970
1975
1980
1985
Year
INJURY ACC.
PROP. ACC.
FATAL ACC.
Source:Ontario Road Safety Annual Report
Min. of Transportation and Communication

Figure 17.3

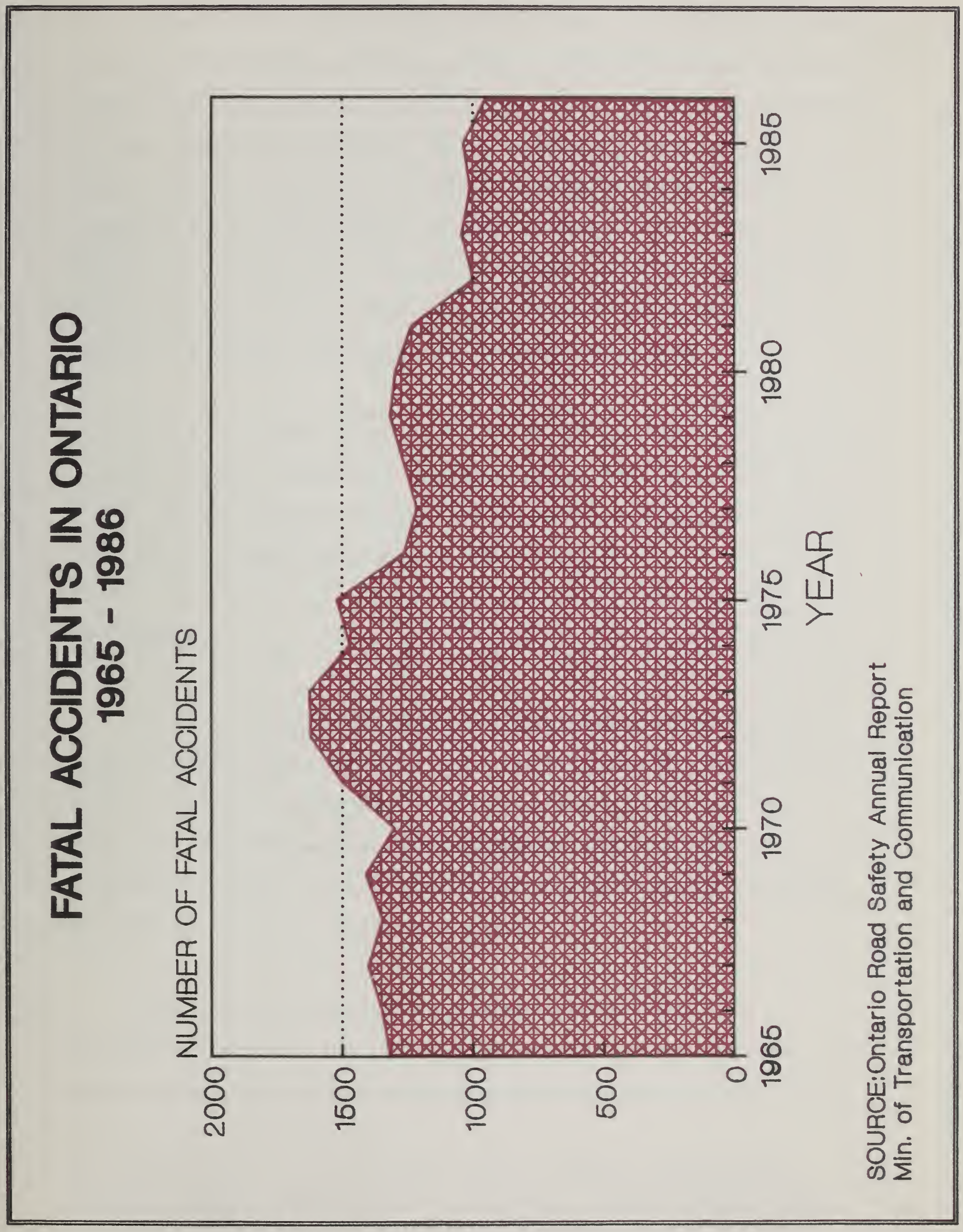

FATAL ACCIDENTS IN ONTARIO
1965 - 1986
NUMBER OF FATAL ACCIDENTS
2000
1500
1000
500
0
1965
1970
1975
1980
1985
YEAR
SOURCE:Ontario Road Safety Annual Report
Min. of Transportation and Communication

Figure 17.3 shows the total number of fatal accidents in Ontario between 1965 and 1986. The 1976 drop in fatal accidents is generally attributed to a reduction in speed limits and the introduction of mandatory seat belt legislation. There is a debate among traffic safety experts as to the impact of each change; there is, however, a consensus that both speed limit reduction and mandatory seat belt legislation worked to reduce the number of fatal accidents on Ontario highways.

To the extent that the number of property damage and bodily injury accidents has increased over the 1965 to 1986 period, that increase is largely attributable to an increase in road use, and roads to use.[6]

(b) Rates

Having briefly referred to the absolute number of motor vehicle accidents, I will next consider the rate of motor vehicle accidents. For road and traffic safety analysis purposes, the rate of motor vehicle accidents is usually measured by the number of motor vehicle accidents per 100 million kilometres driven.

The rate of Ontario accidents per 100 million kilometres driven can be seen on Figure 17.4. Figure 17.4 shows stability in the bodily injury accident rate. The

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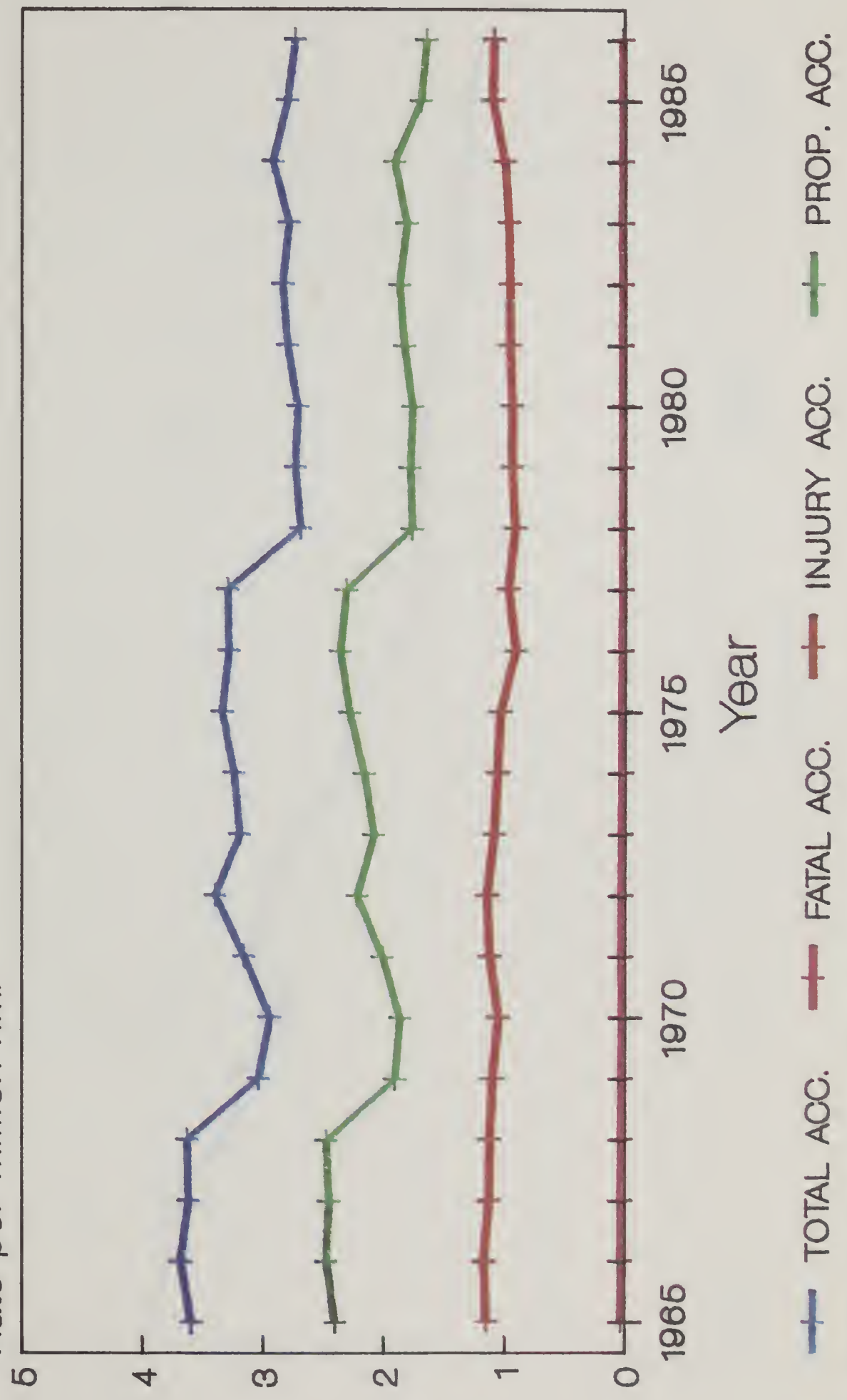
[6]M. Friedland, M. Trebilcock and K. Roach, Regulating Traffic Safety (University of Toronto, 1987) states that road stock increased from 4,655 kilometres in 1931 to 160,142 kilometres in 1985. Kilometres driven increased from .5602 million kilometres in 1931 to 72,419 million kilometres in 1980.

Figure 17.4

ONTARIO ACCIDENT RATES

TYPE OF ACCIDENT PER MILLION KILOMETRES

ONTARIO: 1965 - 1986



Source:Ontario Road Safety Annual Report
Min. of Transportation and Communication

Figure 17.5

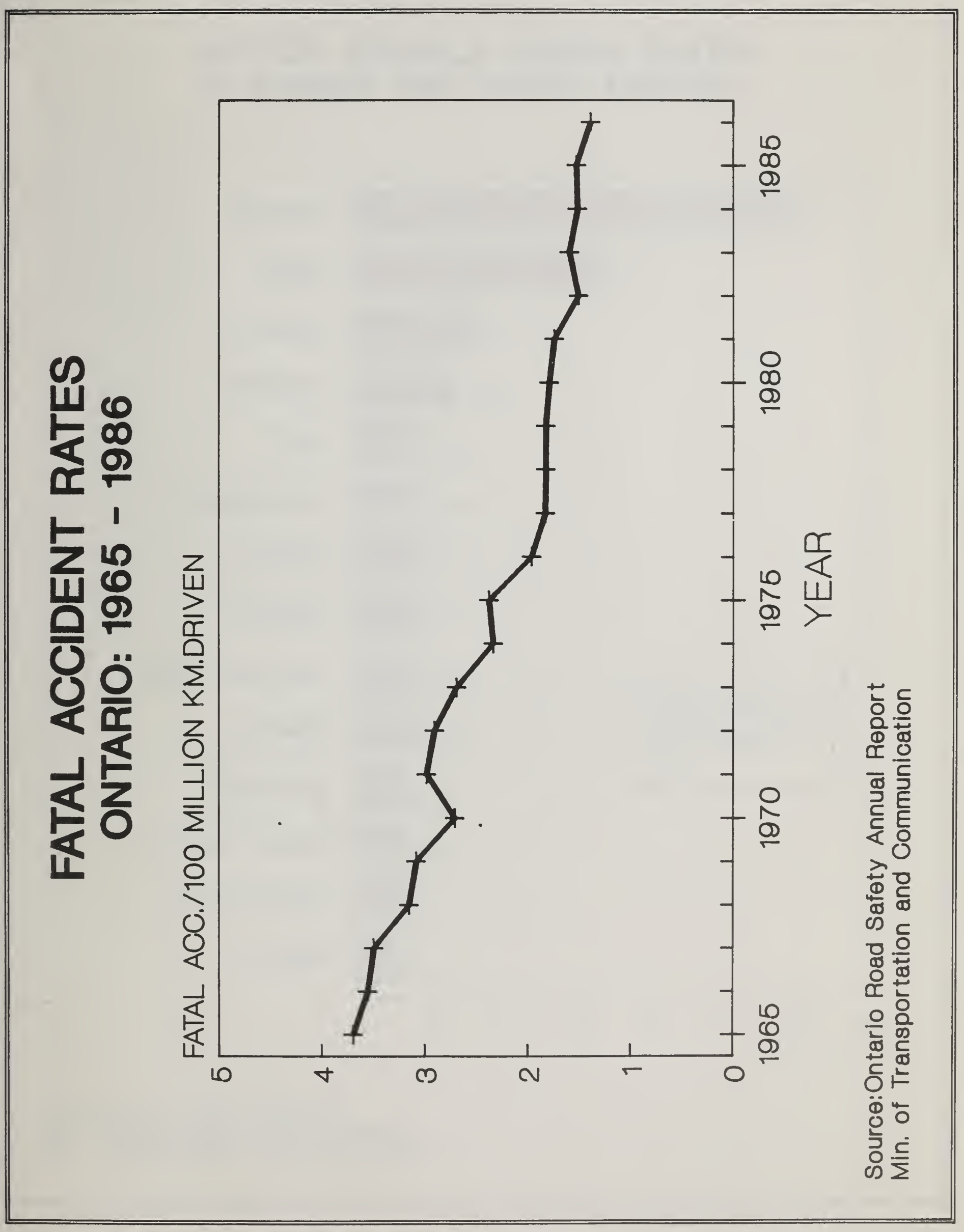
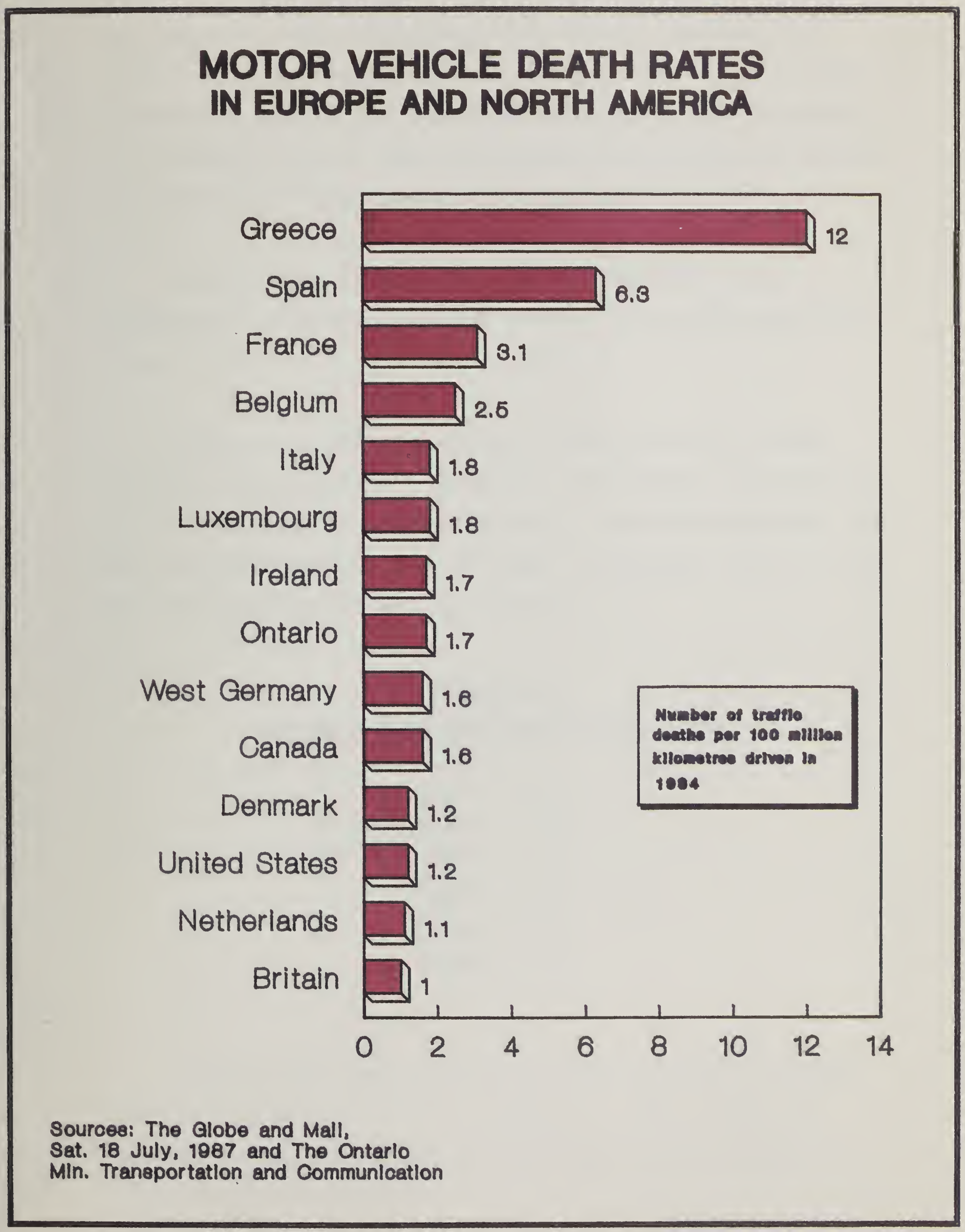

FATAL ACCIDENT RATES
ONTARIO: 1965 - 1986
FATAL ACC./100 MILLION KM.DRIVEN
5
4
3
2
1
0
1965
1970
1975
1980
1985
YEAR
Source:Ontario Road Safety Annual Report
Min. of Transportation and Communication

Figure 17.6


MOTOR VEHICLE DEATH RATES
IN EUROPE AND NORTH AMERICA
Greece
12
Spain
6.3
France
3.1
Belgium
2.5
Italy
1.8
Luxembourg
1.8
Ireland
1.7
Ontario
1.7
West Germany
1.6
Canada
1.6
Denmark
1.2
United States
1.2
Netherlands
1.1
Britain
1
Number of traffic deaths per 100 million kilometres driven in 1984
0
2
4
6
8
10
12
14
Sources: The Globe and Mail, Sat. 18 July, 1987 and The Ontario Min. Transportation and Communication

rate of property damage accidents declined in 1977 and has more or less stabilized since then. Because the number of fatal accidents per million kilometres driven is relatively small, the red fatal accidents line on Figure 17.4 appears flat. The declining rate of fatal accidents has therefore been separately displayed on Figure 17.5.

Ontario and Canada fare reasonably well in a comparison of fatal accident rates, as can be seen from Figure 17.6.

Table 17.1 below sets out Ontario fatality rates between 1931 and 1986. In 1931, 10.2 people were killed per 100 million kilometres driven;[7] by 1950 the death rate had declined to 5.3; and in 1986 1.6 persons were killed per 100 million kilometres driven.

TABLE 17.1

ONTARIO FATALITY RATES 1931 - 1986

1931	10.2
1940	8.6
1950	5.3
1960	4.2
1970	3.2
1980	2.1
1986	1.6

I will deal later with the identification of those involved in motor vehicle accidents. That issue, as related to the effect of age and sex in particular, is

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[7] For road and traffic safety analysis purposes the incidence of motor vehicle accidents is usually measured by the number of accidents per 100 million kilometres driven.

considered in Chapters 6 and 7 dealing with the classification system and premiums.

C. MOTOR VEHICLE ACCIDENT PREVENTION AND TRAFFIC SAFETY

A preoccupation with the frequency and severity of accidents, driver behaviour, the cost of insurance, and compensation systems has tended to relegate accident prevention almost to a point of irrelevance. The frequency of motor vehicle accidents has caused us to become somewhat anaesthetized to their often tragic consequences. The frequency and severity of motor vehicle accidents can be ameliorated by appropriate accident prevention and traffic safety measures.

In Ontario, traffic safety is divided among a number of ministries: Transportation and Communications, the Attorney General, Education, and Health. In May 1976, the Ontario Government established the Select Committee on Highway Safety. In September 1977, that Committee tabled its report. One of the Committee's recommendations was to appoint a provincial highway safety coordinator. This was accomplished by giving additional duties to the Registrar of Motor Vehicles. The Registrar of Motor Vehicles is also the Assistant Deputy Minister of Safety and Regulation. As a result, the Safety Coordination and Development Office was created.

Between 1977 and 1981 a number of projects were undertaken. I will make brief reference to some of these projects. In 1977 through the Ministry of Health, a joint ministry program studied the cost of injuries resulting from motor vehicle accidents; in 1978, a task force established through the office of the Attorney General

undertook a study of drinking and driving and a study on the efficiency of the breathalyzer laws. Other task force projects included studies of seat belt and general safety benefits. The task force often operated in a loose affiliation with other ministries having traffic safety concerns and responsibilities. In February 1981, the Ontario Government established a committee, chaired by the Attorney General, to develop a plan for "Safety In The 80's". In 1982, the committee, for all practical purposes, was disbanded. It was replaced by a special task force given a mandate to study drinking and driving.

In April 1985 the Registrar of Motor Vehicles recommended coordination of traffic safety programs. Although meetings were scheduled it does not appear that anything changed. As matters now stand, no one ministry or inter-ministerial committee has primary responsibility for road and traffic safety. A commendable degree of coordination exists in the area of countermeasures undertaken to combat drinking and driving. Other potential accident prevention and traffic safety measures seem to have a much lower priority.

Because responsibility for motor vehicle accident prevention has not been placed with any one ministry having the responsibility of coordinating traffic safety measures, a patchwork approach to accident prevention has emerged. Funding is of course a problem. Resources are scarce. All departments involved in traffic safety compete for funding. There is an attractively simple logic to the notion that traffic safety would be better organized if responsibility for it were unified, with one budget which could be allocated between various activities

designed to reduce motor vehicle accident fatalities and injuries.

(a) Traffic Safety Research

When considering accident prevention, insurers tend to focus on the singular issue of driver behaviour. Those involved in the field of traffic safety and accident prevention have broadened their horizons somewhat. The literature indicates that a change occurred in the mid-1960s when traffic safety experts came to view accidents and their prevention as something which required consideration of more than driver behaviour. Motor vehicle accidents were increasingly regarded as the consequence of the interaction of three general variables: the driver, the vehicle and the environment. Traffic safety scholars assess accident prevention from a three-phased perspective. First, there is the pre-accident or pre-event phase where in theory an accident can be prevented altogether. Second, there is the event phase, in which it is possible to lessen the injury resulting from an accident. Third, there is the post-accident phase where unreasonable and unnecessary consequences, financial and otherwise, can be avoided.[8]

While traffic safety experts are virtually unanimous in concluding that more than driver behaviour must be taken into account from an accident prevention standpoint, no one suggests that driver behaviour should be ignored.

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[8]W. Haddon and S.P. Baker, "Injury Control" in Preventive and Community Medicine/eds. D.W. Clark and B. MacMahon (Boston: Little, Brown, 1981).

Vehicle design, road design and driver behaviour all need to be considered.

(b) Vehicle Design

Until Ralph Nader's book, Unsafe At Any Speed[9], made vehicle design a political hot potato, the vehicle design issue remained in a state of dormancy. This was not so much because of the silence of traffic safety experts and scholars, but because no one seemed to listen to them. In 1956, the Ford Motor Company offered an optional safety package on new models; although 43% of Ford's customers chose to purchase vehicles with the Ford safety package, it was abandoned the following year. Some have suggested that pressure from other automobile manufacturers led to this decision.[10] A few years later the president of General Motors rejected the concept of a safety package, such as the one Ford had introduced in 1956 "until a very high proportion of the customers select the item or there are compelling reasons for standard installation".[11] In the end, neither Ford, General Motors nor Chrysler offered factory-installed safety features as an optional package after Ford's commendable effort in 1956. What the consumer would have chosen to purchase is therefore a matter of pure speculation.

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[9]R. Nader, Unsafe At Any Speed: The Design-in Dangers of the American Automobile (New York: Grossman, 1965).

[10]J. Claybrook and D. Bollier, "The Hidden Benefits of Regulation: Disclosing the Auto Safety Pay-off," Yale J. of Regulation 3 (1985): 87-131.

[11]Claybrook and Bollier.

Certain facts are beyond dispute. In the late 1960s and the early 1970s there was an explosion of safety literature dealing with design-related issues. At about the same time, there was an increase in the intensity of the debate over vehicle design. Whether research sparked the debate, or the debate sparked the research, is no longer important. Although estimates vary as to the percentage of injuries prevented as a result of vehicle design improvements, the evidence is clear that research in this area has been enormously valuable.[12]

After the publication of Unsafe At Any Speed in 1965, the United States Government Operations Committee and the Senate Commerce Committee held public hearings which resulted in the establishment of the National Highway Safety Bureau. This later became the National Highway Traffic Safety Administration (NHTSA). The National Traffic Motor Vehicle and Safety Act was passed in the United States in 1966. In 1967, NHTSA issued 19 vehicle safety standards. Many think that these standards led to a new era in traffic safety. These American standards have served as a model for many countries, including Britain, West Germany, France, Australia and Canada.[13]

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[12] Friedland, Trebilcock and Roach, Regulating Traffic Safety; Robert W. Crandall et al.; Regulating the Automobile (Washington, D.C.: Brookings Institution, 1986); U.S. General Accounting Office, Effectiveness, Benefits and Costs of Federal Safety Standards for Protection of Passenger Car Occupants (Washington, D.C.: N.H.T.S.A., Dept. of Transportation, 1976).--(E.D. 76-121 G.A.O. 1976).

[13] The Motor Vehicle Safety Act 1970.

There were, of course, dissenters. Using a mathematical model and data from 1944 to 1972, Professor Samuel Peltzman[14] hypothesized that the NHTSA safety regulations were not responsible for the existing decline in accident frequency and severity. Peltzman's central premise was that drivers equipped with safer vehicles take more risks with the result that accident involvement remains static. Groups opposing government intervention (or promoting freedom of choice) assembled under the Peltzman banner. At times the debate became more ideological than empirical. The spillover into Canada was limited.

A recent study, which appears both extensive and methodologically sound, concluded that the 1967 regulations previously referred to resulted in a 30% reduction in fatalities. Assuming this estimate is correct, the 1967 U.S. regulations adopted in Canada in 1971 may have saved 472 lives in Ontario in 1986.[15]

The vehicle safety regulation debate continues. Each new technological development leads to two central questions. First, will the technological development reduce accidents and costs (fatalities, bodily injuries, vehicle damage)? Second, if the answer to the first question is yes, is the investment required cost

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[14] S. Peltzman, "Effects of Automobile Safety Regulation," J. of Pol. Econ. (1975): 677-725.

[15] 1,102 people were killed in motor vehicle accidents in Ontario in 1986. If the 30% estimate is correct, there would have been 1,574 deaths in Ontario without the safety regulations.

efficient? This second question requires ascribing an economic and social value to human life.

(c) Road Design

It is now recognized that making driving safer can be achieved by making the roadways themselves safer. The research is prolific; it is not possible here to begin to outline what is known about highway design and traffic safety. I propose to restrict my comments to some of the general concerns in this area.

The traffic engineer is often faced with a dilemma. Safety and mobility often conflict. Value judgments have to be made. For example, four-way stops, although safer than two-way stops,[16] slow down traffic. Safety considerations must be taken into account in road construction and on an ongoing basis, so that existing potential danger areas can be identified before, not after, tragedies occur.

(d) Driver Behaviour

There are countless aspects of driver behaviour which are taken into account in traffic safety literature. I will restrict my comments to issues of speed, restraint systems and drinking and driving.

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[16] E. Hauer, Review of Published Evidence on the Safety Effect of Conversion from Two-way to Four-way Stop Sign Control, (Toronto: University of Toronto, Dept. of Civil Engineering, 1985). - (Publication # '85-02).

(i) Speed Limits

There is no doubt that speed influences both the severity and frequency of motor vehicle accidents. The connection between speed and accident severity is both simplistic and obvious. The greater the speed upon impact, the larger the force of impact and consequently, the greater the injury, all else being equal. Speed also affects accident frequency. As speed increases, response time decreases. Increased speed tends to establish increased variation in travel speed from that of the surrounding traffic flow. In this area it is not absolute speed which is the issue, but rather the variation in speed between a subject vehicle and other traffic.[17] Absolute speed and variations in vehicular speed are therefore significant. This raises the issue of maximum and minimum speed limits.

A Ministry of Transportation and Communications study undertaken by J.A. Pierce[18] in 1977 evaluated the safety benefits from the reduction of speed limits in Ontario in 1976. At that time speed limits on major divided highways were reduced from 70 miles per hour (112.6 kilometres per hour) to 60 miles per hour (96.5 kilometres per hour), and on undivided highways from 60 miles per hour to 50 miles per hour (80 kilometres per hour). The Pierce study found

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[17] See particularly, National Research Council. Transportation Research Board, 55: A Decade of Experience (Washington, D.C.: National Research Council, 1984).--(Special Report #204).

[18] J.A. Pierce, "Safety Benefits of the Seat Belt Legislation and Speed Limit Reduction in Ontario," in Proceedings of the 23rd Annual Conference of the American Association of Automotive Medicine (Illinois: A.A.A.M., 1977).

that the speed limit reduction resulted in a positive, if unquantifiable, safety benefit. Pierce concluded that it was impossible to separate the influence of new speed limits in Ontario from benefits accruing from the simultaneous introduction of mandatory seat belt legislation. Thus, in Ontario, as in New Zealand (where speed limit reductions were imposed along with seat belt legislation and no fault insurance) and the United States (where speed limit reductions were imposed at a time when road use declined due to the oil crisis), conclusions about the extent of life-saving benefits of reduced speed limits remain somewhat speculative. In a field where disagreement is the norm, the conclusion that speed limit reduction will beneficially affect accident frequency and severity, is close to unanimous. The debate is over the extent, not the existence, of the benefit derived from reduced speed limits.

Some impressive research has demonstrated that the important link between speed and accident risk is not based exclusively upon the absolute vehicle speed, but also on vehicle speed in relation to the surrounding traffic flow.[19] Variability in vehicle speeds results in more passing as faster drivers overtake slower moving cars. As each passing event occurs, there is an increased risk of collision for both the passing and the passed vehicles. If, as some suggest, it is correct that the lowest accident frequencies occur not at the lowest speeds, but at the median speed, then travelling at the median speed should place a driver in the best statistical

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[19] See National Research Council. Transportation Research Board, 55: A Decade of Experience, 1984 and especially E. Hauer, "Accidents, Overtaking and Speed Control," Acc. Anal. and Prev. 3 (1971): 1-13.

risk position. Travelling at above or below the median speed increases the driver's risk of accident involvement. Thus, while speed reduction is important to safety from the standpoint of both accident frequency and severity, speed control, consisting of reducing high speeds and increasing low speeds to close the speed variation gap, may be equally important. In this respect, minimum speed limits and their enforcement may well be as important as establishing and enforcing the maximum speed at which vehicles can be driven.

(ii) Restraint Systems

In an accident where there is bodily injury there are two separate collisions. The first involves the contact between the vehicle and some other object, often another vehicle; the second collision occurs when the driver or passenger hits some surface within the vehicle, or if propelled out of the vehicle, the road. Restraint systems are designed to avoid or at least limit this second collision. For present purposes I refer only to seat belts and child restraints.

Studies on the efficacy of seat belts have been undertaken since seat belts were first used by pilots after World War I. Surprisingly, it was not until 1964 in the United States, and 1972 in Canada, that simple lap belts became mandatory equipment on new cars. That seat belts save lives and reduce injuries is beyond argument. There will, of course, always be those who deal with seat belts in a negative and anecdotal way; all have heard stories of the driver trapped in his car by a seat belt that could not be unhooked. These "man-bites-dog" stories

should not be allowed to obscure the overwhelming evidence as to the value of seat belts.

It was originally estimated that seat belts would result in a 40 to 50% reduction in serious injuries and fatalities.[20] Reductions have occurred, but predictions have not been met. When Ontario made seat belt use mandatory in 1976, the fatality/injury rate did not drop by 40 to 50%. Not everyone buckled up; those who chose not to tended to be high risk drivers, more likely to be involved in accidents in the first place. Moreover, some suggest that drivers who were forced to use seat belts increased risk-taking in other areas, thus tending to stabilize accident rates on a before-and-after seat belt law assessment basis.

Although the benefits of seat belt laws are difficult to quantify because of the influence of other variables such as reduced speed limits, most experts in the field of traffic safety and accident prevention agree that the use of seat belts has had a beneficial effect on accident severity.[21]

There is no doubt as to the value of using child restraints. Because the skulls of small children are softer than those of adults and constitute a

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[20] J. Hedlund, "Recent U.S. Fatality Trends," in Human Behavior and Traffic Safety/eds. L. Evans and R.C. Schwing (New York: Plenum, 1985).

[21] See for example, O.E.C.D., Symposium on Occupant Restraints (Paris: 1985); University of Toronto, Human Collision: International Symposium on Occupant Restraint (Toronto: 1981).

proportionally larger part of body area, a young child's capacity for injury on secondary contact within the vehicle is greater than that of an adult. Furthermore, U.S. figures show that 11% of children under 14 who are treated in emergency rooms are injured either while riding in a car that has swerved or stopped, rather than crashed, or injured as a result of a fall from the opened door of a stationary vehicle. Potential reductions in injuries and fatalities attributable to child restraints have been estimated at 80%.[22] The actual results have been less significant, mainly because of non-use and misuse of child restraints.

The benefits of child restraints are so demonstrably clear that there is little reason to justify children sitting loose in a car, or on the lap of an adult in the passenger seat. Child restraints are readily available; in many areas they can be obtained on loan. Child restraint loan programs were pioneered in New Zealand and are now widespread in Canada. Educating parents through information provided in hospitals and in doctors' offices concerning child restraints as is done now makes sense to me. Furthermore, I think we should consider what is done in some American jurisdictions when a parent is charged with an offence related to the failure to use a child restraint. The parent is given a choice of paying the fine or establishing to the court that a child restraint has been purchased, rented or borrowed.

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[22] Hall et al., The Use of Telephone Interviews to Verify the Reliability of Police Accident Reports in Assessing the Effectiveness of Child Safety Seats (Chapel Hill: Highway Safety Research Centre, Univ. of North Carolina at Chapel Hill, 1984).

(iii) Drinking and Driving

Prior to 1969 a charge of impaired driving or driving while intoxicated required a subjective judgment concerning the driver's condition. There was no accepted objective method of determining what constituted a condition of impairment or intoxication. Although blood alcohol test results were admissible as evidence, they were neither required nor was the fact of a refusal to take a test admissible.

In 1969 the Criminal Code was amended. The offence of driving while intoxicated was removed from the Code. Driving while impaired remained. A new offence was introduced, that being driving with a blood alcohol level of over 80 milligrams of alcohol per 100 millilitres of blood (.08). At the same time the offence of refusing to provide a breath sample was created. Impaired driving, driving with a breathalyzer reading in excess of .08 and the refusal to take a breathalyzer test carry the same penalties.

Police are now authorized to conduct roadside breathalyzer tests, not only on reasonable and probable grounds that the driver is impaired, but also on reasonable and probable grounds that the driver has a blood alcohol reading of more than .08.

It is clear that drinking and driving is no longer socially acceptable. The development of this response has been slow; however, its manifestations are increasingly visible. What is not as clear is how this additional change has occurred. Some argue that increased penalties

and enforcement are the causal factors; others suggest that society's recently adopted abhorrence of impaired driving has led to increased penalties and more zealous enforcement.

As Dr. White has pointed out in his Inquiry research paper, changes in social attitudes do not occur overnight; the gestation period is lengthy. Changes in attitudes related to drinking and driving do not come about in isolation or in singular response to increased penalties; dissemination of relevant information is required. Recently, a British Columbia project of spot checks to control drinking and driving was undertaken. The program was accompanied by a wide publicity campaign in all major communities but one. In that one community there happened to be a newspaper strike. Alcohol-related accidents decreased in all communities except the community in which there had been no publicity.[23] It would appear that public education and publicity are an effective and essential operating force in molding social attitudes as to what is acceptable behaviour, and in the final analysis, modifying behaviour.

Rehabilitation programs seem to be of benefit in modifying the behaviour of social drinkers, but not problem drinkers. Education and publicity programs may succeed in informing but not, in isolation, modifying behaviour.[24] Most of those convicted of impaired driving have sufficient information; what they do not have is the

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[23] Friedland, Trebilcock and Roach, Regulating Traffic Safety.

[24] Friedland, Trebilcock and Roach.

willingness or, in some cases, the capacity to modify their behaviour.

Licence suspensions deter in both a specific and general way. At the specific level, deterrence works in three ways. First, an accused whose licence has been suspended for a drinking and driving charge is said to be less likely to drink and drive in the future. Second, in the short run, the accused (it is hoped) will not drive during the suspension period. Third, if the accused does drive, he will tend to drive more carefully for fear of being caught.

At the general level, licence suspensions for drinking and driving are said to deter others from similar activity. There is no doubt that the exposure to a licence suspension, now one year for a first conviction in the impaired driving family of offences,[25] has acted as a general deterrent. The motorist's response to the certainty of a minimum one-year licence suspension following an impaired driving conviction is quite different from the motorist's response to traffic violations (for example, convictions for breaches of the Highway Traffic Act's Rules of the Road). As Dr. White observes, breaches of the rules of the road tend to be viewed by motorists simply as a cost of mobility; that kind of offence is not regarded as morally culpable either on an individual or on a community basis.[26] In my opinion, increasing the flow of information as to the imposition of the suspension on drinking and driving

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[25] See Appendix V.

[26] See Inquiry Research Study V.

convictions, more than the probable fine or even the potential of imprisonment, would be productive.

It seems to me that there is no single control device which has a significant influence on either behaviour or accident rates as related to drinking and driving. Friedland, Trebilcock and Roach, in their recent study, Regulating Traffic Safety: A Survey of the Effectiveness of Control Strategies, conclude that drinking and driving can best be controlled with a comprehensive approach involving multiple accepted methods, such as, education, publicity, licence suspensions, increased penalties and enforcement. While certain scholars disagree, the comprehensive approach outlined above makes sense to me. The authors caution that ongoing evaluation is crucial.

Some of those making submissions to this Inquiry have suggested increasing the drinking or driving age, or both. The most common proposal is that the drinking and driving ages be increased to 21. In dealing with these issues from the traffic safety standpoint, I think it is important that the drinking age and the driving age be separated. If the drinking and driving ages are coincident, the roads will be partly occupied by those who have neither learned to drink nor drive. At the moment, there is a three-year difference between the drinking and the driving age. Raising the drinking age to 21 would increase the gap to five years, but it would not improve the documented inferior risk perception capacity of young drivers;[27] nor would it eliminate the need to deal

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[27] P. Finn and B.W.E. Bragg, "Perception of the Risk of an Accident by Young and Older Drivers," Acc. Anal. and Prev. 18, No. 4 (1986): 289.

eventually with combining the two forms of activity, drinking and driving, in a responsible and safe way. I have not examined sufficient evidence to make recommendations as to increasing either the drinking age or the driving age. From a traffic safety standpoint, I recommend only that both the drinking and driving ages be given further study.

One of the difficulties with the driving age itself is that of inexperience. A young driver, almost by definition, has little or no driving experience, except that gained through driver education or through whatever training is undertaken in preparation for the individual's acquisition of a driver's licence. Dr. White[28] has noted that the young driver's "cognitive set" is established well before the young driver is licensed. It would be sensible for young people undertaking driver training to be given driver education at a much younger age, and not as part of a crash course leading to the acquisition of a driver's licence. Establishing in a young would-be driver what is acceptable social behaviour may be difficult in some instances, but not impossible.

I conclude this chapter by emphasizing that we must devote adequate resources to accident prevention. As Professor Gaudry has observed,[29] even minor statistical positive changes in injury and fatality rates will translate into fewer lives lost and fewer injuries sustained. What should not be forgotten is that advances

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[28] See Inquiry Research Study V.

[29] Inquiry Compensation Conference, May 15, 1987, Toronto.

in traffic safety do not have to be revolutionary in the statistical sense to be legitimately viewed as worthwhile.

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